Exploring reasons for clients' non-attendance at appointments within a community-based alcohol service: clients' and practitioners' perspectives.

F. Mahmood

PhD 2021

Exploring reasons for clients' non-attendance at appointments within a community-based alcohol service: clients' and practitioners' perspectives.

Faisal Mahmood

A thesis submitted in partial fulfilment of the requirements of

Manchester Metropolitan University

for the degree of Doctor of Philosophy

Department of Sociology

Manchester Metropolitan University

2021

Abstract

Aims: The main aim of this research was to gain a deeper understanding of the reasons for clients' non-attendance at appointments within a community-based alcohol service, from the perspectives of clients and practitioners.

Background: Clients' non-attendance is a widespread issue in addiction treatment services (Milward et al., 2014). Non-attendance at appointments delays clients' recovery processes and increases overall service delivery cost. This research project investigates reasons for clients' non-attendance from both clients' and practitioners' perspectives and explores strategies to improve clients' engagement and attendance.

Design: A mixed methods study was conducted. First, secondary analysis was conducted on an existing dataset comprising 194,679 treatment appointments detailing 22,405 clients' attendance history for four years (Jan 2010 – Dec 2013). The clinical data was analysed using a hierarchical four-stage binary logistic regression model to identify factors predicting non-attendance. Second, a qualitative strand sought practitioners' perspectives (one-to-one semi-structured interviews; n=15) and clients' perspectives (one focus group; n=8). The qualitative data were analysed using a template analysis approach.

Results: Quantitative strand (logistic regression): Clients with the following characteristics were more likely to be recorded as 'did not attend (DNA)'; those aged between 18-24 and 75+ years old compared to other age groups; people on employment support allowance; people who were economically inactive due to mental ill health; those recorded as long-term sick or disabled; people assessed with high risk levels; and young persons in settled accommodation. Clients who live with 'some of their children', had 'none of the children with them' and the clients 'who were not parents' were more likely to not attend compared to clients who have all their children living with them. Two appointment time slots 15.30-15.59pm and 11.00-11.29am increased the likelihood of non-attendance, whereas the 11:30-11:59 time slot reduced non-attendance by 74.5% (comparison group: 9:30-9:59am). Gender, smoking status, pregnancy status, and dual diagnosis did not significantly predict non-attendance.

Qualitative strands: Practitioners' and clients' perspectives – Template analysis was used to analyse the semi-structured interviews with practitioners (n=15) and a focus group with clients (n=8). According to practitioners, certain client characteristics (the most prominent being younger clients, BAME people, and people with complex needs or in early recovery stages) were linked with higher non-attendance rates. Forgetfulness was reported by both groups (clients and practitioners) as the most common reason for clients' non-attendance. DNA is also reported as a systems need – practitioners rely on the missed appointment times to undertake their administrative tasks. The key findings of the clients' focus group analysis show that positive client-practitioner relationships support higher attendance rates. It suggests that practitioners' lived experiences of addiction further enhance the client-practitioner relationship. Both groups of participants (clients and practitioners) referred to a lack of funding and resources impacting directly on service provision and clients' engagement.

Conclusions: The findings of this mixed methods study suggest a range of steps to improve clients' attendance. These include additional funding for community-based outreach services, reducing waiting times, change of service delivery paradigm from a traditional 'outpatient' model to more creative methods of engagements. Additionally, improvements might include more group work, appropriate support for practitioners, use of text message reminders, use of phone-based interventions, and practitioners using 'DNA' time effectively by contacting the clients. The research thesis presents an innovative concept of 'co-created motivation' as a relational phenomenon that impacts the client-practitioner working alliance and clients' attendance.

Acknowledgments

First, I would like to thank to all those who participated in this study because without their support and participation this study would not have been possible.

I would like to thank Dr Sarah Galvani (Director of Studies) for her support, kindness and millions of annotated comments. I also would like to thank Dr Lucy Webb, Dr Gemma Yarwood, Dr Cherilyn Dance and Dr Andy Guppy (UoB) for their kind support over the years.

This study would have been possible without the support of Aquarius Action Project. Thank you Annette Fleming, Richard McVey, Ben Howell, Tom Cleverly, and Tonia Clark for your support and encouragement. I also would like to acknowledge support from my colleagues at Newman University.

Finally, thank you to my family; Nuzhat, Adam, Isha and Inaya for your support and patience.

Table of Contents

Abstract 2

Acknowledgments 4

List of Figures 11

List of Tables 12

Chapter 1 Introduction 13

1.1 Terminology 16

1.2 Alcohol addiction 17

1.3 Alcohol addiction - definitions 18

1.4 Harms of alcohol drinking 21

1.5 Local alcohol context 24

1.6 UK treatment provision 25

1.7 The agency's profile 25

1.8 Rationale for this research project 29

1.9 The focus of this research 31

1.10 Structure of the thesis 32

Chapter 2 Literature Review 34

2.1 Search strategy 34

2.2 Methodologies of included studied 36

2.3 Overview of included papers 38

2.4 Summary of the key findings 55

2.5 Non-attendance at treatment 56

2.6 Client-related factors 57

2.7 Service-related factors 64

2.8 Therapeutic relationship 66

2.9 Retention in treatment 69

2.10 Improving attendance 72

2.11 Chapter summary 76

Chapter 3 Theories of Addiction 78

3.1 The Disease Model 79

3.2 PRIME theory 81

3.3 Gestalt Therapy Theory 82
3.4 Attachment theory 84
3.5 Chapter summary 86
Chapter 4 Methodology 87
4.1 Methodology overview 87
4.1.1 Research aims 87
4.1.2 Research objectives 87
4.1.3 Research Design 88
4.1.4 Literature review strategy for methodology 89
4.1.5 Pragmatist paradigm 90
4.1.6 Methodological considerations 93
4.1.7 Mixed methods approach 96
4.1.8 Mixed methods multi-strand parallel design 97
4.1.9 Quality control and triangulation 99
4.2 Quantitative strand 102
4.2.1 Aim and objectives (Quantitative strand) 102
4.2.2 Research questions (Quantitative strand) 103
4.2.3 The existing dataset 103
4.2.4 Summary of the dataset 103
4.2.5 Secondary data analysis 107
4.2.6 Data analysis 109
4.2.7 Data transfer Excel to SPSS process 110
4.2.8 Rationale for using logistic regression 111
4.3 Qualitative strand 111
4.3.1 Practitioners' perspectives 113
4.3.1.1 Research aim and objectives (Practitioners' perspectives) 113
4.3.1.2 Research questions (Qualitative strand – practitioners' perspectives) . 113
4.3.1.3 Sampling 113
4.3.1.4 Participants 114
4.3.1.5 Sites 115
4.3.1.6 Recruitment procedure 115
4.3.1.7 Data collection tool 116

4.3.1.8 Pilot Study 117
4.3.1.9 Data analysis 118
4.3.2 Clients' perspectives 120
4.3.2.1 Research aim and objectives (Clients' perspectives) 120
4.3.2.2 Research questions (Qualitative strand – clients' perspectives) 120
4.3.2.3 Participants inclusion criteria 121
4.3.2.4 Recruitment challenges 121
4.3.2.5 Participant recruitment 122
4.3.2.6 Focus group 123
4.4 Ethical considerations 126
4.4.1 Data protection (quantitative strand) 128
4.4.2 Participant information sheets (qualitative strands) 129
4.4.3 Informed consent (qualitative strands) 129
4.4.4 Withdrawal of consent 130
4.4.5 Confidentiality and its limitations 131
4.4.6 Data storage 131
4.4.7 Safety of researchers and participants: 132
4.5 Reflexivity 133
4.6 Chapter summary 137
Chapter 5 Results and Discussion – Quantitative Strand 138
5.1 Hierarchical Logistic Regression to Determine Predictors of Non-Attendance 138
5.1.1 Assumptions of logistic regression 139
5.1.2 Interpreting Logistic Regression Odds Ratios 140
5.1.3 Summary of Results: Significant Predictors of Non-attendance 140
5.1.4 Testing the Impact of Sociodemographic Factors on Non-attendance 140
5.1.5 Gender is Not a Significant Predictor of Non-Attendance 141
5.1.6 Age Group Significantly Predicts Non-Attendance (18-24 and 75+ years) 141
5.1.7 Ethnicity Significantly Predicts Non-Attendance 142
5.18 Current Employment Status Significantly Predicts Non-Attendance 142
5.1.9 Accommodation Needs Significantly Predict Non-attendance 142
5.1.10 Parental Status Significantly Predict Non-attendance 143
5.1.11 Number of Children Living with Client is A Significant Predictor 143

5.1.12 Testing the Impact of Clinical History Factors on Non-Attendance 143
5.1.13 Overall Discharge Reason Significantly Predicts Non-Attendance 144
5.1.14 Clinical Risk Level Significantly Predicts Non-attendance 144
5.1.15 Smoking Status: Not a Significant Predictor 145
5.1.16 Pregnancy Status: Not a Significant Predictor 145
5.1.17 Dual Diagnosis: Not a Significant Predictor 145
5.1.18 Testing the Impact of Receiving an SMS Message Reminder on Non-Attendance 145
5.1.19 Testing the Impact of Event Time on Non-Attendance 146
5.2 Discussion 150
5.2.1 Age 153
5.2.2 Ethnicity 154
5.2.3 Smoking and Other risk factors 157
5.2.4 Sites/Use of family interventions 157
5.2.5 SMS reminders 158
5.2.6 Time of the appointment 159
5.3 Chapter summary 161
Chapter 6 Findings – Practitioners' Views 163
6.1 Practitioners' perspectives – individual interviews 163
6.2 Sample profile 163
6.3.1 Reasons for non-attendance 166
6.3.2 'Magic spark': co-created motivation to attend 184
6.3.3 DNA: a system's need 191
6.3.4 What needs to happen: 'Change of paradigm' 196
6.4 Discussion 211
6.5 Chapter summary 212
Chapter 7 Findings – Clients' Views 214
7.1 Participants demographics 214
7.2 Reasons for non-attendance 216
7.2.1 Client-related factors 216
7.2.2 Service-related factors 221
7.3 Client-practitioner relationship 225
7.4 How the attendance can be improved 228

7.5 Discussion 230
7.6 Chapter summary 234
Chapter 8 Discussion 235
8.1 Divergent and convergent findings 236
8.2 Reasons for non-attendance 239
8.2.1 Age 239
8.2.2 Ethnicity 242
8.2.3 Clients with multiple needs 245
8.3 Clients' patterns 247
8.3.1 Early recovery stages 247
8.3.2 Forgetfulness 248
8.4 DNA – a system's need 251
8.5 Client-practitioner working alliance: Impact of practitioners' personal addiction experiences 253
8.6 How to improve clients' attendance? 256
8.7 Chapter summary 259
Chapter 9 Development of a Working Model: Co-created Motivation 261
9.1 Motivational Interviewing (MI) 266
9.2 Practitioners' motivation - Compassion fatigue 270
9.3 What works in therapy? 272
9.4 The dialogical relationship 274
9.5 Co-created motivation 277
9.6 Chapter summary 281
Chapter 10 Conclusions and Recommendations 283
10.1 Limitations and strengths 285
10.2 Implications 287
10.2.1 Policy implications 287
10.2.2 Practice implications 289
10.2.3 Research implications 290
References 292
Appendices 339
Appendix A Literature search terms 340

Appendix B UoB ethics approval 341
Appendix C Ethics amendment applications and approvals (MMU) 342
Appendix D Participant information sheets and consent forms 351
Appendix E Participating organisation's approval 355
Appendix F Practitioners' Interview guide 356
Appendix G Post interview reflection form 360
Appendix H Reflective journal example 361
Appendix I Clients' – Focus group guide 363
Appendix J Chi-square analysis 368
Appendix K Template Analysis – Templates 379

List of Figures

Figure 1.1: Research phases 15
Figure 1.2: Alcohol use health implications; Source – PHE (2018) 22
Figure 1.3: The costs of alcohol-related harm 23
Figure 1.4: NICE (2011) guidelines for alcohol use disorder 27

Figure 2.1: Flow chart of the literature selection process (PRISMA) 36

Figure 3.1: COM-B model; Source: West and Brown (2013) 81
Figure 3.2: Cycle of experience; Source: Joyce and Sills (2018) 83

Figure 4.1: Overall research design 88
Figure 4.2: Research design and paradigm 90
Figure 4.3: Theoretical foundations; Source: Adapted from Crotty (1998: 4) 94
Figure 4.4: Mixed-methods multi-strand parallel design adapted from Morse's illustration 98
Figure 4.5: A visual model of a mixed methods research study. Source: Creswell (2003) 99
Figure 4.6: The triangulation process 101
Figure 4.7: Qualitative strand research design (Phase 1 = quantitative strand) 112
Figure 4.8: Stages of a focus group; Source: Finch et al. (2014: 218) 125

Figure 6.1: Clients' characteristics: sub-themes 166
Figure 6.2: Service-related factors: sub-themes 176
Figure 6.3: Impact of funding cuts 181
Figure 6.4: 'Magic spark: co-created motivation to attend': sub-themes 185
Figure 6.5: Use of DNA time 194
Figure 6.6: Creative engagement strategies suggested by practitioners 197
Figure 6.7: Offering a flexible service 204
Figure 6.8: Types of proactive follow-up 207

Figure 7.1: Client-related factors 216
Figure 7.2: Service-related factors 221

Figure 8.1: Illustrative diagram of the findings from the qualitative data strands 238

Figure 9.1: Illustration of co-created motivation 263
Figure 9.2: Illustration of practitioner-client relational interplay, adapted from Mahmood (2020) 279

List of Tables

Table 1.1 NICE recommended alcohol treatment interventions 28

Table 2.1 Literature search strategy 35
Table 2.2 Methodologies and research areas of included studies 37
Table 2.3 Summary of key studies included in the literature review 39
Table 2.4 Factors associated with poor attendance rate 55

Table 4.1 Positivist vs Constructivism; Source: Adapted from Teddie and Taskakkori (2009: 88) 91
Table 4.2 Key features of pragmatism (Teddie and Taskakkori, 2009: 88) 92
Table 4.3 Summary of multi-strand mixed methods designs 97
Table 4.4 Data variables (quantitative strand) 104
Table 4.5 Steps by step data transfer process from Excel to SPSS 110
Table 4.6 Focus group ground rules 124

Table 5.1 Hierarchical logistic regression results predicting non-attendance with socio-demographic, clinical history, SMS message reminder, and event time. 146
Table 5.2 Summary of chi square analysis 151

Table 6.1 Participants' (Practitioners) demographics 164
Table 6.2 Template Analysis: main themes and themes template 165

Table 7.1 Participants' (clients) demographics 215
Table 7.2 Public Health England guidelines for commissioners and service providers regarding co-occurring conditions (Christie, 2017: 23) 232

Table 8.1 Summary of quantitative results and qualitative findings 236

Table 10.1 Key contributions of this research 285

Chapter 1 Introduction

At some level, I first started working on this research project over 20 years ago – though I never imagined that I would one day enrol on a PhD programme. Waiting for my clients to turn up and speculating about the possible reasons for their non-attendance led me, as an alcohol practitioner, to start searching for plausible explanations. The notion that there was 'something missing' became figural in my search for the answer. At an obvious level, there was something missing in the counselling room when my clients did not turn up – my clients! However, on another level, there was something missing in my understanding of what was happening for my clients in relation to their absence. Wondering about this 'missing link' planted the seed for this research project. This study is primarily an attempt to find the missing link that could offer a comprehensive theoretical and practical explanation for clients' non-attendance and how to improve clients' engagement.

I have worked over 20 years in the addiction field working in a range of roles; alcohol counsellor, hospital alcohol counsellor, senior practitioner, and alcohol service manager. I have worked thousands of clinical hours supporting clients with their alcohol addiction issues. My own personal experiences of addiction (smoking) for 15 years, including nearly 10 years of a smoke free life, and supporting a close friend with severe drinking issues, offered me the opportunity of invaluable lived experience. I can trace back my interest in clients' non-attendance from my early days of clinical work. At times, I was really surprised when my clients did not turn up after, in my experience, a very productive session a week before. Some clients surprised me because they turned up when I did not expect them to attend. As a service manager, I was determined to improve clients' attendance to improve staff efficiency and effectiveness as well as in the service of clients' recovery journey. I judged my clients' non-attendance in a number of ways, for example that they were not motivated enough to change, they must have relapsed, not committed to their treatment, and they do not value 'free' support services provided by tax payers' money. In my earlier years of practice, I almost always blamed clients for not turning up, until I worked with John[1]. John, was a White British client in his early 50s with long term alcohol addiction issues. He had

[1] A pseudonym to protect client's identity.

several hospital admissions with liver problems, accident and emergency visits after accidental injuries and medical detoxifications. I first met John after his recent hospital discharge. He had not been drinking for four days and appeared very committed to change his drinking. I experienced him as very motivated and engaging in the first session. However, he did not turn up for his second session. After two letters and a phone call he decided to attend his second session. I started the session with a straight question, 'what happened?'. He said, 'I found our last session repetitive and boring. I have been hearing and talking the similar things for years with different practitioners. I did not think I will learn anything new and this (addressing his alcohol issues) is something I just have to do myself'. John was right. He has been attending alcohol support services for nearly ten years and I was quite a new practitioner. I was mainly using scripted and manualised interventions. John had clearly passed the stage where interventions like, 'on the scale of 1 to 10 how important is it for you to stop drinking' or 'what are the pros and cons of your drinking', had any positive impact. I found myself at a crossroad where I could have stayed with my script using a somewhat superficial intervention or I could offer a dialogical intervention based on honesty, congruence and authenticity. In essence, John was objecting to scripted, surface level, and robotic interventions. I decided to be a real person. I named my disappointment when he did not turn up for his second session. This was truly a turning point in our work. I noticed that something changed in him hearing my disappointment. He said it was refreshing to hear my real voice. From there onwards, our sessions were more real, genuine and person to person meetings. John would regularly attend his sessions and he would often tell me what was helpful and what was less effective. I was more open to his feedback and felt less defensive. This experience changed two things for me as a practitioner; I started using more Gestalt therapy theory interventions in my addiction work (I was qualified as a Gestalt counsellor) and I stopped blaming my clients when they did not turn up. I invested in the process of a three-level reflective practice exploring three dimensions of my contact with my clients; what was going on for them, what was going for me and what was happening between us?

My experience suggests a client's non-attendance is a message or feedback about their contact with a practitioner and we (practitioners) need to listen to these messages. These messages might be that life is too much at the moment, I cannot stop drinking, not

drinking is too painful, I know more than you about drinking and life, do not see any value in making an effort to turn up, too embarrassing to face that I relapsed last week, I have been lying for weeks about not drinking, this support is too little too late, I do not want any help and you are an inadequate practitioner. It is important to engage with these messages as directly as possible. There is an extensive research body supporting the significance of therapeutic relationship in the treatment outcomes (see chapter 2 – Literature review).

In this research project, I endeavoured to have a greater understanding of contributing factors in the clients' decision-making process to not attend their alcohol support sessions. I wanted to understand how clients and practitioners made sense of their experiences of missed sessions. In addition, I was interested in developing a knowledge-based resource that can support reshaping service provision and commissioning in order to enhance clients' attendance.

To respond to these research questions, this mixed methods study is based on analysis of an existing dataset recording client details and attendance, semi-structured interviews with practitioners and a focus group with clients from a community-based alcohol agency (see Section 1.7) located in the West Midlands, United Kingdom (UK) (see Figure 1.1 below).

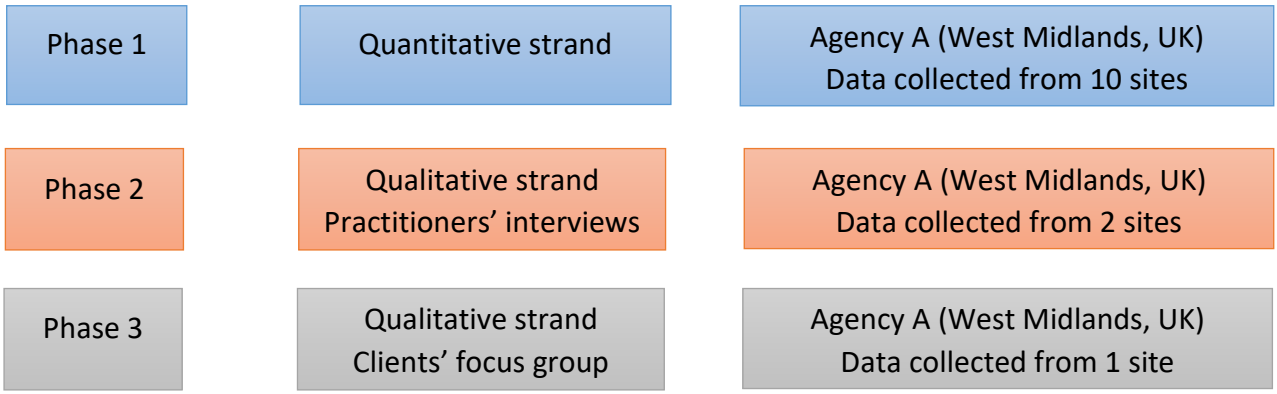


Figure 1.1: Research phases

The Figure 1.1. illustrates three phases of this research; phase 1 – based on a quantitative strand in which I analysed an existing dataset from agency 'A' (a Midlands-

based alcohol agency), phase 2 – based on individual interviews with 15 practitioners, and phase 3 – based on a focus groups of eight clients.

In the next section, I will set out key statistical information in relation to excessive alcohol drinking harms, discuss various definitions of alcohol addiction, and present the negative impact of excessive alcohol drinking on people's health and wider society. I will also review alcohol treatment provision in the UK, and set out the aims of this research and structure of this thesis.

1.1 Terminology

Two key concepts are at the core of this research and require clarification at this point: Addiction and DNA (Did Not Attend). There are different 'terms' used in the literature to describe a person with alcohol issues and/or their behaviour. These terms included, for example; alcohol addiction, alcoholism, alcohol misuse, alcohol abuse, problematic drinking, alcohol dependence, alcohol use disorder, harmful drinking, hazardous drinking, increasing risk level of drinking, and others. Specific terms represent specific political or clinical epistemological viewpoints. To explore these differences is beyond the scope of this research thesis. In the service of coherent writing, the term 'addiction' will mainly be used to denote a range of overlapping terms used in the addiction literature, including in research and academic papers, such as; misuse, abuse, dependency, problems, issues, and disorder. In certain situations, I will be using the term/language used by the authors cited. The term addiction is most widely used in the research literature and policy documents (NHS, 2018; White, 2009) and it is used in this thesis with no allegiance to any specific school of thought such as the medical model, Alcohol Anonymous or the Minnesota Model (Anderson et al., 1999).

Non-attendance (DNA – did not attend) at appointments is a widely discussed concept in the field of addiction, and more broadly in physical and mental health studies. NHS data-coding systems define DNA as 'did not attend – no advance warning given' (datadictionary.nhs, 2018). The term DNA (did not attend) will be used in addition to non-attendance in this thesis. The clients' non-attendance negatively impacts the service providers' resources, increases the service delivery cost, and risks clients' reaching their treatment goals (Coulson, et al., 2009). Previous studies have mainly focused on

determining client-related factors relating to their non-attendance. However, there is a paucity of studies exploring both clients' and practitioners' experiences of clients' non-attendance; particularly a lack of qualitative studies and practitioners' perspectives about their client's non-attendance.

Next, I will discuss the definition of alcohol addiction, harms of alcohol addiction, treatment provision, the aims and rationale for this research and the overall structure of this thesis.

1.2 Alcohol addiction

In order to understand clients' reasons for non-attendance at a community-based alcohol agency, it is important to explore what impact alcohol has on people. Developed countries, particularly in Europe, are generally amongst those with the highest alcohol consumption rates (WHO, n.d.). The harmful effects of alcohol have a major impact on public health, contributing to health problems, injury and loss of life. The detrimental impact of alcohol is not confined to the drinker alone, it also adversely affects other people's well-being, such as drink driving victims, financial burden on tax payers, domestic violence, and stillborn babies (Anderson, et al., 2011). Alcohol has now become a part of our social and cultural fabric with the majority of people drinking at moderate levels or abstaining and thus not developing any problematic physical or psychological issues (NHS, 2018). However, in England about 10.8 million adults drink at levels that pose risks to their health, 2.2 million drink at levels that pose an even higher-risk of harm and 1.6 million may have some level of alcohol dependence in England (PHE, 2016). According to Public Health England (2016), the total cost to society of alcohol-related harm is estimated to be £21bn per annum. The National Health Service (NHS) incurs a £3.5bn cost per annum related to alcohol use and there is an £11bn estimated cost to our criminal justice system (PHE, 2016). In 2016/17, there were 337,000 alcohol related hospital admissions, which was approximately 17% higher than in 2006/7 (NHS, 2018).

1.3 Alcohol addiction - definitions

Definitions of alcohol addiction vary. Indeed, the notion of 'addiction' is a contested one. According to the Oxford English Dictionary (OED) and Merriam-Webster Dictionary addiction is defined as:

> Immoderate or compulsive consumption of a drug or other substance; a condition characterized by regular or poorly controlled use of a psychoactive substance despite adverse physical, psychological, or social consequences, often with the development of physiological tolerance and withdrawal symptoms. (OED, n.d.).

> A compulsive, chronic, physiological or psychological need for a habit-forming substance, behavior [sic], or activity having harmful physical, psychological, or social effects and typically causing well-defined symptoms (such as anxiety, irritability, tremors, or nausea) upon withdrawal or abstinence. (Merriam Webster Dictionary, n.d.).

Both of these definitions seem almost identical with an emphasis on compulsivity, harmful physical, psychological and social consequences of excessive substance use, and the presence of withdrawal symptom.

West and Brown (2013: 15) describe addiction as a chronic condition involving a repeated powerful motivation to engage in a rewarding behaviour, acquired as a result of engaging in that behaviour, that has significant potential for unintended harm. Someone is addicted to something to the extent that they experience this repeated powerful motivation. Nutt and Nestor (2013) explain substance addiction as a chronic relapsing state encompassing compulsive intake of a substance, lack of control in reducing substance intake and the presence of a negative emotional state. The Diagnostic and Statistical Manual of Mental Disorders – 5 (American Psychiatric Association, 2013) and the International Statistical Classification of Diseases and Related Health Problems (World Health Organisation, 2016) are globally used diagnostic manuals and they offer varying operational and descriptive definitions of addiction.

Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM V) definition:

DSM V (American Psychiatric Association, 2013) highlights seven main criteria for substance dependence; tolerance (gradually increasing the intake amount to have desired effect), withdrawal, frequency and intensity of substance intake, persistent desire to use and failure to control intake, extensive use of time spent relating to substance use activities, lack of interest in other life domains (for example, social activities or work), and continue to use substance despite their harmful consequences (American Psychiatric Association, 2013).

The International Statistical Classification of Diseases and Related Health Problems – 10 (ICD – 10) defines substance dependence (World Health Organisation, 2016) as:

> "A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals" (ICD 10, 2016).

Both DSM-V (2013) and ICD-10 (2016) diagnostic definitions agree on a person's overwhelming desire to use a substance despite negative consequences, the notion of physiological tolerance, and prioritising substance use over other activities. ICD-10 (2016) also refers to the relapsing nature of substance addiction, whereas, DSM-V (2013) includes withdrawal symptoms in its diagnostic criteria.

Despite the ICD and DSM definitions of addictions, many academics and researchers present contesting views to conceptualise and theorise addictive behaviours. This includes, for example, the notion of free will and choice to engage in addictive behaviours (Vohs and Baumeister, 2009), addiction as a myth (Davies, 1992), the excessive appetite model (Orford, 2001), the theory of rational addiction (Becker and Murphy, 1988), addiction as a self-medication process (Gelkopf et al., 2002), opponent process theory (Solomon, 1980), choice theory (Skog 2000), cognitive bias theory (Field et al., 2004), disease model (Jellinek, 2010), inhibition dysregulation theory (Lubman et al., 2004, learning theory (Drummond et al., 1990), social learning theory (Bandura, 1977), identity theory (Walters, 1996), and

PRIME theory (West and Brown, 2013). It is beyond the scope of this thesis to discuss these in detail. In brief, the diverse theoretical perspectives present different psychological processes to describe and conceptualise addiction, however, there is a shared understanding of behavioural manifestation of addiction, such as, compulsivity, negative outcomes, increased tolerance, and lack of control.

In an attempt to consolidate definitions, Sussman and Sussman (2011) conducted a systematic literature review comprised of 52 studies based on definitions of addiction and presented five elements of an addictive behaviour; i. engagement in the behaviour to achieve appetitive effects, ii. preoccupation with the addiction behaviour, iii. short-term satisfaction, iv. lack of control, and v. harmful consequences. Cann (2012) warns against definitions of addiction that are too narrow and lead to 'microscopic pathology in an individual'. Cann (2012) suggests a broader definition that includes biological, interpersonal, social, transpersonal and intergenerational dimensions.

The definition I have adopted for this study draws on this wider conceptualisation of addiction: 'substance addiction is a chronic, recurring condition in which a person experiences a lack of control and engages in a compulsive behaviour to continue to use a substance despite its negative consequences'. The decision-making process, ambivalence and conflict are consistent and central features of substance addiction (Heather, 1998).

There are several forms of addiction (Nutt, 2013) which can be broadly divided into two main areas; substance-related addictions (for example; drugs, alcohol) and behaviour-related addictions (for example; gambling, pornography). Alcohol, drugs, legal highs, food, and prescribed medication are examples of substance addiction, whereas behaviour-related addiction includes excessive work, exercise, electronic devices, gaming, gambling, sex, shopping, pornography (NHS, 2018). I believe such a distinction between substance related and behaviour related addictions can be helpful in the service delivery, policy development and commissioning strategies, however, it seems overly simplistic division. Both substance and behaviour related addictions share many common processes, such as; changes in the levels of neurotransmitters, engaging in a behaviour despite its negative consequences, and an obsessive-compulsive and relapsing nature.

The UK Chief Medical Officers (gov.uk, 2016) presented the revised advisory guidelines regarding alcohol drinking styles and divided into three risk categories; lower-risk drinkers (low risk of causing future harm, increasing-risk drinkers (increases the risk of damaging health) and higher-risk drinkers (higher risk of damaging health) (NHS, 2015). It is worth noting that there is no safe drinking category because drinking within guided limits, 14 units of alcohol per week, is not completely risk free (Tomberg, 2010). The key function of these risk categories was to support primary care health practitioners and frontline workforce such as, social workers, dentists, nurses, probation officers, teachers, and housing officers, in the early detection of alcohol misuse, brief advice and onward referrals to specialist addiction agencies for additional support. By definition, excessive alcohol drinking is associated with negative consequences such as, health (both physical and mental), social, relationship, housing, and employment issues. The next section will explore the harms of excessive alcohol drinking.

1.4 Harms of alcohol drinking

In 2004, UK Cabinet Office Strategy Unit (2004) published a report on harms of alcohol drinking. The key findings of this cabinet report have not been revised since 2004. This report categorised the harms of alcohol in four broad groups; i) health, ii) crime, iii) productivity, an iv) social;

- Health related harm – a range of physical and psychological health problems associated with alcohol such as liver problems, cancer, depression
- Crime – such as anti-social behaviour, drink-driving, assault, breach of peach
- Loss of productivity – such as work-absence due to alcohol-related health and social issues, accidents at workplace
- Social harm – such as relationship issues, problems with families, negative impact on children and young people

Excessive alcohol drinking is associated with a range of serious physical health problems (Figure 1.2). Alcohol problems can cause, or adversely contribute to, liver dysfunction, pancreatitis and digestive disorders, cardiac problems, blood circulation, poor nutrition, cancers and alcohol-related brain damage (PHE, 2013). Frequent intoxication may

lead to accidents and injuries. Excessive drinking during pregnancy may lead to foetal alcohol syndrome (PHE, 2016).

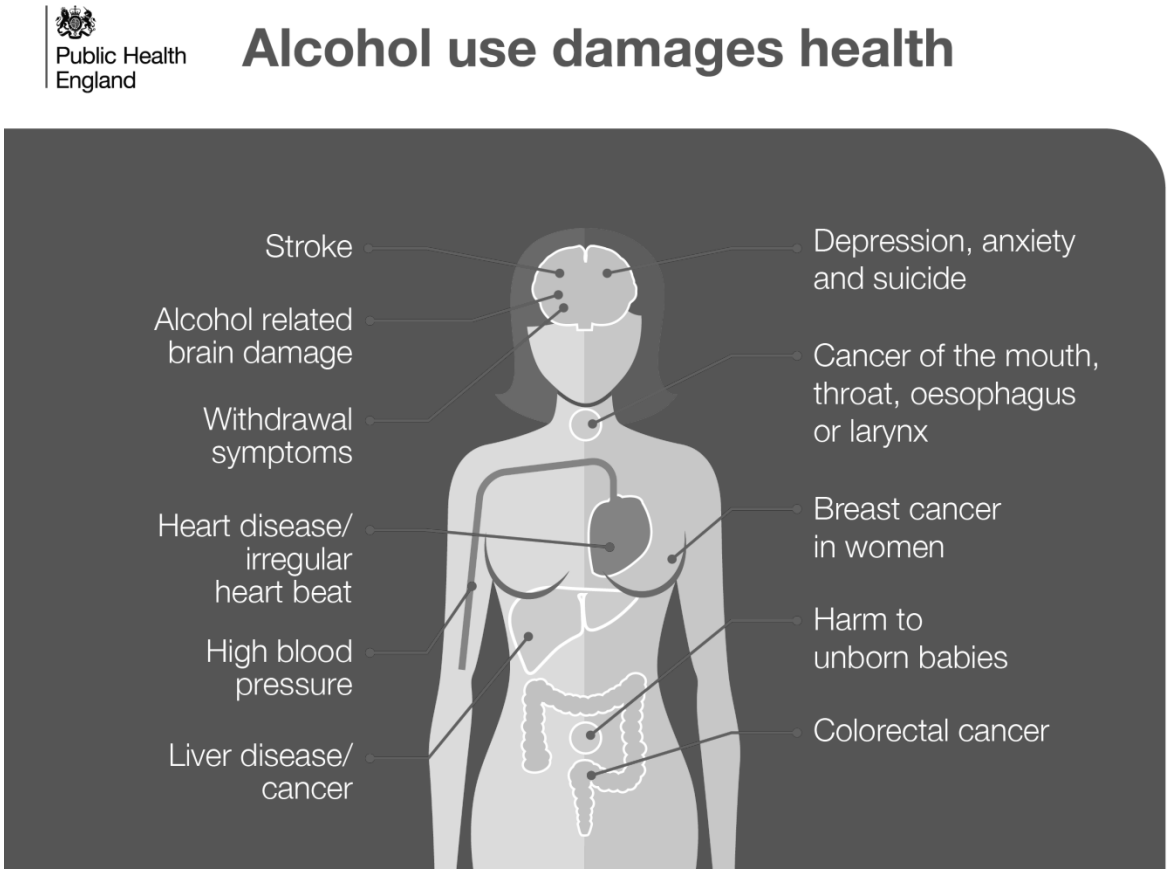


Figure 1.2: Alcohol use health implications; Source – PHE (2018)[2]

People with alcohol problems can also suffer from psychiatric distress or disturbed moods. Anxiety, panic attacks, personality disorders and depression are some of the mental health issues commonly associated with heavy alcohol consumption (PHE[3], 2016). Approximately 20% of the population has an increased-risk style of drinking in England whereas, alcohol dependence affects approximately 1.1 million people, that is, 4% of the adult population in England (NICE[4], 2011). Alcohol addiction is one of the key lifestyle risk factors for disease and death in the UK. In 2018, 7,551 alcohol-specific deaths were

[2] No permission was required to reuse this material

[3] Public Health England

[4] The National Institute for Health and Care Excellence

registered in the UK (Office for National Statistics, 2019). In spite of these alcohol harms, nearly 7.5 million people in the UK lack essential knowledge about the harms of their excessive drinking (PHE, 2016). In addition, alcohol is now more affordable than in the past suggesting people are at greater risk of alcohol harms than ever before (PHE, 2016). PHE (2016) reports that approximately 1 million hospital admissions are alcohol-related per year and about half of these admissions are alcohol-related cardiovascular conditions.

Anderson and Baumber (2006) reported that the cost of alcohol-related harms was approximately 1% to 3% of gross domestic product (GDP[5]) in Europe, that is, between $65 billion – $195,000 billion at 1990 prices (Anderson and Baumber, 2006). The Alcohol Harm Reduction Strategy for England (2004) presented the following figure (see Figure 1.1 below) to highlight the social cost (people, society & environment related costs) of alcohol-related harm in the UK.

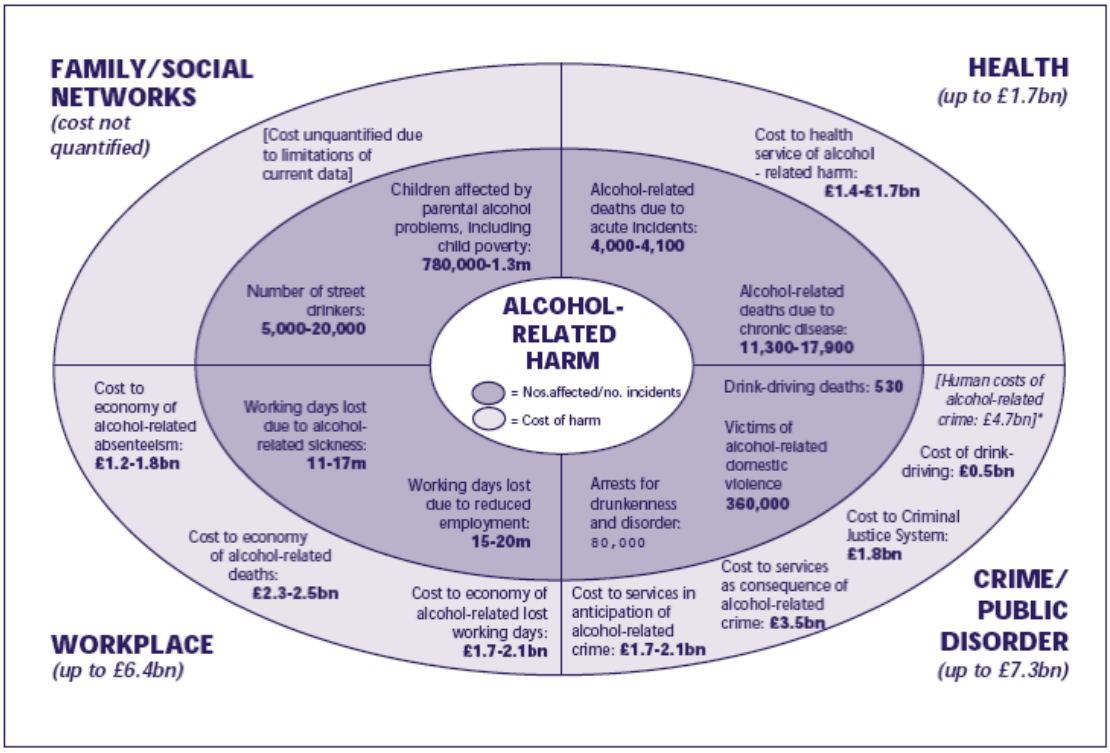


Figure 1.3: The costs of alcohol-related harm[6]

Source: Alcohol Harm Reduction Strategy England (2004)

[5] GDP = a measure of the size and health of a country's economy over a period of time
[6] No permission was required to reuse this material

On the basis of above mentioned definitions of addiction, alcohol addiction can be described as a bio-psycho-social problem and excessive drinking is linked to a range of physical health, mental health and social issues.

Alcohol misuse is linked to a range of social, relational and personal issues. For example, parental alcohol misuse can have a detrimental effect on the wellbeing of children (Adamson and Templeton, 2012). A range of crime and offending behaviour, such as violent crime and domestic abuse, is also reported to be associated with alcohol addiction (PHE, 2017). Public Health England (2016) estimates that the alcohol addiction cost to national employment related productivity is about £7 billion.

The above discussion explored harmful consequences of excessive alcohol drinking in relation to England (UK) and European context. The next section will explore local - West Midlands (UK) based statistical information because this study collected data from a West Midlands-based alcohol agency.

1.5 Local alcohol context

According to Local Alcohol Profiles for England (LAPE), the West Midlands has a number of significant issues in relation to alcohol addiction. The West Midlands region has higher hospital admission episodes for alcohol-related conditions; higher alcohol-related mortality and higher alcohol-specific mortality compared to the England average in 2016/17 (PHE, 2018). The number of claimants of benefits due to alcoholism (2016) and the number of alcohol-related road traffic accidents (2014-16) were also higher in the West Midlands compared to the England average. Birmingham and Solihull have lower rates of successful completion of treatment for alcohol compared to the England average. Birmingham also has a higher percentage of dependent drinkers (2014-15) compared to the England average. Unfortunately, Public Health England statistical reports (PHE, 2018) do not offer any qualitative narrative to explain such regional differences. To set this study in context, the next section will explore the UK-based treatment provision and include NICE guidelines regarding alcohol addiction treatment provision.

1.6 UK treatment provision

At the core of this research is a UK-based community alcohol service, this section will set this agency in the context of the wider alcohol treatment scene in the UK and the training and development of practitioners who staff it.

Alcohol treatment in England is mainly provided by the third sector (voluntary sector) which is comprised small to large not-for-profit organisations (Buykx et al., 2020) . Historically, the medical component of treatment such as detoxification, was mainly provided by mental health services within the NHS. However, in the last few years many private and charity-registered organisations also started offering addiction related medical treatment in many areas in the UK such as West Midlands. For example, CGL (Change, Grow, Live) – a registered charity offers both medical and social interventions for a range of substance-based addiction issues (CGL, n.d.). The agency at the core of this research is also a third sector organization comprising nearly 200 staff and, at the time of writing, thousands of people seeking alcohol, drug or gambling support. It does not have its own medical prescribers, however, it works in partnership with a range of NHS and other third sector organisations. Next, I will present the profile of this agency.

1.7 The agency's profile

As mentioned above the data was collected from a West Midlands, UK-based organisation (a registered charity). It was established in 1970s to run residential services as part of a local university research project, to develop effective interventions for people with alcohol issues. Forty years on, this organisation is now well established and offering its treatment services from a number of cities in the West Midlands. It offers:

- a free and confidential service; providing alcohol advice and support including 1:1 and/or group sessions;
- onward referrals to detoxification, residential rehabilitation, and other services (housing, social services, mental health etc.);
- support to affected family and friends.

The service vision is "that individuals, families and communities should have the opportunity to lead full and empowered lives that are free from the negative influences of alcohol, drugs and gambling". The following statement is provided on its website:

At …… we strive to help people overcome the harms caused by alcohol, drugs and gambling. We work closely with individuals, families and friends to lessen the impact caused by the behaviour of a loved one. Overcoming an addiction can be a difficult process but you can be sure that our staff will be dedicated to giving you and your family the attention and support that you need. We will be there to help you with each step of your journey along the way to recovery and to help you look forward to the future with the confidence that change is possible.

Its theoretical framework is based on the social ecological model. This model offers a holistic view with regard to the issues of addiction that the abuse of alcohol, drugs and gambling not only impact individuals but their families, communities and our society. The service treatment approach includes elements of Personal Skills Training which is based in a cognitive behavioural approach. The main concepts that underpin its approach are:

- That people use substances to cope with a variety of problems,
- That people are responsible for thoughts, feelings and actions and are capable of change,
- That people can change given the right support and alternatives to drinking.

(Agency's website, 2018)[7]

The agency delivers a range service level contracts commissioned by the local government bodies in different regions on the West Midlands. These contracts are based on the PHE guidelines (PHE, 2018) in relation to addiction service provision.

In line with the NICE guidelines and the local government bodies commission their local addiction service as per PHE pathways (PHE, 2018). It is, therefore, relevant here to explore further the NICE guidelines in order to understand the UK alcohol treatment

[7] Due to confidentiality requirements, the name of the organisation and the website reference are not included in this thesis.

provision. The NICE (2011) guidelines for alcohol use disorders advise a stepped or tiered approach in order to address the diverse and complex needs of people with drinking issues. Figure 1.3 presents the summary of NICE (2011) guidelines for alcohol use disorders;

Nature of problem	Interventions	Desired outcome
Alcohol misuse (No physical dependency)	Motivational interviewing (MI) • Psycho-education • Enhance self-awareness • Resolve ambivalence • Encourage positive change • Supportive and persuasive approach Setting: Community based service	Abstinence or moderate drinking Relapse prevention
Moderate to severe alcohol dependence (People with limited support, complex physical or mental health issues, homeless, or not responded to M.I)	Intensive structured community-based interventions • Pharmacological treatment • Evidence based treatment • Outcome focused • Residential rehabilitation for 3 months • Case management approach • Transition to stable housing (if homeless) Setting: Structured community-based services	Abstinence Relapse prevention

Figure 1.4: NICE (2011) guidelines for alcohol use disorder

NICE (2011) guidelines specify particular psychological and pharmacological interventions for alcohol addiction. Table 1.1 shows specific interventions relating to severity of drinking problems.

Table 1.1 NICE recommended alcohol treatment interventions

Psychological therapies	Pharmacological interventions for alcohol dependency
Focus on cognition, behaviour and social networks • Cognitive Behaviour Therapies • Behavioural therapies • Behavioural couples' therapy • Social network and environment-based therapies	• To support relapse prevention consider Acamprosate, oral Naltrexone in combination with psychological therapies • Assisted withdrawal support in specialist alcohol services or specialist units ○ For mild withdrawals and no complex associated issues (such as health, housing, social support) – community based withdrawal assisted support ○ For mild to moderate dependency – outpatient based assisted withdrawal support ○ For mild to moderate dependency and complex needs or sever dependence – intensive community programme ○ Severe dependency or history of severe health conditions – inpatient or residential assisted withdrawal services

Local government bodies and Clinical Commissioning Groups (CCGs) commission a range of treatment services in accordance with Public Health England and NICE guidelines, as well as the Government's drug strategy (2017). At a regional level, alcohol treatment provision is delivered by a combination of statutory (NHS) services, specialised addiction charities, and private service providers. There is currently no data publishing the number of alcohol services in the UK. Overall, most English regions offer alcohol support services comprising a range of psychological and pharmacological interventions. These interventions include; brief advice (from frontline professionals such as GPs, nurses, pharmacists),

structured psychological interventions (motivational interviewing, Social Behaviour and Network Therapy, Cognitive Behaviour Therapy), pharmacological interventions (Acamprosate, Disulfiram, medically assisted detoxification), peer support based programmes (SMART, AA), residential rehabilitations, and now growing online self-help interventions. The quality and effectiveness of the current alcohol support provision has been seriously compromised in the last ten years mainly due to extensive funding cuts (alcoholchangeuk, 2018) (see Chapter 6: Qualitative strand for detailed discussion regarding funding cuts).

In the above section, I have discussed different definitions of alcohol addiction, harms of excessive alcohol use, the UK-focused alcohol treatment provision, and information about the agency in which this research project is located. Different perspectives on addition share common themes; compulsivity, continue to use substance despite their harmful consequences, lack of intake control, developing tolerance, and presence of withdrawal symptoms. There is a substantial evidence of harms of excessive alcohol drinking including health, relationships, family, social, employment, finances, housing, and many more problems. In the UK, a range of treatment options available such as screening, brief advice and information, structured care plan interventions, inpatient detoxification, and residential rehabilitation. In order to understand the reasons for clients' non-attendance at a community-based alcohol agency, it was important to explore the above mentioned relevant contextual issues. To study clients' non-attendance at their sessions, it was important to explore the nature of these sessions. The next section will discuss the rationale for this research project.

1.8 Rationale for this research project

Most behaviour-changing interventions rely on clients' attendance and engagement with treatment services. However, non-attendance is a common and costly issue in addiction treatment services. Non-attendance at treatment has been broadly researched in substance abuse and drug addiction (see Chapter 2 – Literature review). However, only limited information could be found on the reasons for non-attendance at alcohol community services. Most of the previous research focused on 'drop out/withdrawal from treatment' instead of 'missing or not attending sessions' but not necessarily dropped out

from the treatment. Missing appointments in many cases will result in clients dropping out and any focus on understanding and designing interventions based on that understanding could in turn reduce the dropout levels. There also has been limited attention given to experiences of front-line staff regarding their clients' non-attendance.

There is no published research available in the UK or globally in relation to the cost of non-attendance at alcohol addiction services and therefore it is difficult to assess the cost to alcohol service providers and commissioners. NHS outpatients missed appointments costs are the closest comparative findings. Pal et al. (1998) reported approximately £50 cost to the NHS with each missed appointment. After 10 years, this figure is now approximately £120 per missed outpatient hospital appointment, costing NHS approximately £1 billion in total in 2017/18 (NHS, 2018). According to a *Guardian* newspaper report in January 2018, non-attendance at appointments cost the NHS £1bn in 2017 (Slawson, 2018).

As the detailed review of the literature will show (see chapter 2), the existing body of research (globally) on this topic mainly consists of quantitative studies based on a comparatively small samples. There is no published research available that focuses on practitioners' experiences of their clients' non-attendance in the context of alcohol treatment provision. There is a paucity of mixed methods research in exploring the above mentioned research questions. The key aim of this research was to explore reasons for clients' non-attendance at an alcohol community service and what can be done to improve clients' attendance by reducing the DNA (did not attend) percentage. It was important to analyse a large existing dataset to establish relationships among different variables to predict any contributing factors. The existing dataset provided useful insights into trends of clients' engagement patterns. The qualitative strand set out to triangulate this data by exploring practitioners' and clients' experiences of clients' non-attendance and their suggested strategies for improving attendance.

In brief, this research is significant because clients' non-attendance at a community-based alcohol service has public health implications directly impacting clients' wellbeing and service provision. Community-based services are a cost-effective method to support people with alcohol dependence and can reduce admissions to hospitals and provide efficient and effective care interventions (Department of Health, 2009). Non-attendance and, ultimately,

dropout could mean that the client in the future may need to access other services with additional associated issues, such as, physical and mental health services, social services, criminal justice, and housing services. In the absence of empirical research, it was essential to explore and understand reasons for clients' non-attendance and ways to improve clients' attendance. Clients need engagement and support in order to reduce non-attendance levels (Nordheim at al., 2018), therefore understanding the core variables linked with non-attendance is key to reducing these levels. The next section will discuss the focus of this research project.

1.9 The focus of this research

This mixed methods research project (qualitative and quantitative) set out to explore reasons for clients' non-attendance at scheduled one-to-one sessions at a community-based alcohol service. The overall research design involved three forms of data collection; secondary analysis of existing agency data (a quantitative strand), practitioners' perspectives (qualitative strand) and clients' perspectives (qualitative strand) (see Chapter 4: Methodology for detailed research design discussion). The focus of the quantitative and qualitative data collection were similar but they were underpinned by two different sets of research questions. The key research questions for the quantitative strand were;

- To what extent do socio-demographic factors of clients such as age, gender, ethnic origin, employment status, accommodation needs, parental status, and number of children living with client predict non-attendance?
- Do clinical factors for clients such as risk levels, smoking status, pregnancy, dual diagnosis, and overall discharge reasons predict non-attendance?
- Do the receipts of text messages (appointment reminders) predict non-attendance?
- Do the scheduled session times predict non-attendance?

The qualitative strand was based on individual interviews with practitioners (n=15) and a focus group with clients (n=8). The key research questions of qualitative strand were;

Individual interviews (practitioners' perspectives):

- What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service in the practitioners' views?
- How do practitioners view and experience their clients' non-attendance – exploring their (practitioners) thoughts, feelings, interpretations and behaviours?
- What do practitioners think will improve their clients' attendance?'

Focus group (clients' perspectives) :

- What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service?
- How do clients make sense of their 'non-attendance' – exploring their thoughts, feelings, interpretations and behaviours?
- What features do clients suggest may improve their attendance?

The research in this thesis set out to answer these research questions. The following section details the structure of the thesis in an attempt to provide those answers.

1.10 Structure of the thesis

This PhD research thesis consists of seven chapters, the breakdown of each chapter is given below;

Chapter 1 Introduction: includes a brief overview of definitions of addiction and overview of alcohol problems nationally and locally, brief background to this study and an overview of the structure of the thesis.

Chapter 2 Literature Review: includes the appraisal of existing research in this area. This chapter comprises the literature search strategy and review of previous research.

Chapter 3 Theories of addiction: includes critical discussion of different addiction theories.

Chapter 4 Methodology: includes the aims and objectives of this research, research questions, the rationale of using a mixed methods approach, details of both quantitative and qualitative methods, data collection, data analysis approaches and ethical issues.

Chapter 5 Results and discussion (Quantitative strand): includes the secondary analysis of an existing dataset, results including logistic regression, and discussion in relation to the secondary analysis.

Chapter 6 Findings and discussion (Qualitative strand – practitioners' perspectives): includes the findings and discussion of the individual interviews with practitioners.

Chapter 7 Findings and discussion (Qualitative strand – client's perspectives): includes the findings and discussion of the focus group with clients.

Chapter 8 Integrated discussion: includes discussion of the findings from both quantitative and qualitative strands.

Chapter 9 Theoretical development: presents a novel theoretical concept developed from this research. The idea of co-created motivation offers a nascent understanding of complex practitioner-client relational dimensions that impacts both parties including motivation to attend sessions.

Chapter10 Conclusion and recommendations: includes a concluding summary of this research thesis, an outline of the strengths and limitations, and implications for further research, practice and policy.

Chapter 2 Literature Review

This research aims to gain a deeper understanding of the reasons for clients' non-attendance at appointments within a community-based alcohol service. In this chapter, I will explore previous research focusing on factors related to non-attendance at substance misuse services and issues of non-attendance in a wider context such as other health related services.

2.1 Search strategy

In this section (2.1), I will present an overall literature search strategy, a detailed review of relevant studies and critical analysis of the previous literature and narrative review (Coughlan et al. 2013). A thorough literature search (Appendix A) was undertaken at the start of the research to inform the development of the research questions, aims and objectives. The search revealed limited previous research work which directly addressed non-attendance by clients at alcohol support services. No studies were found which addressed practitioners' experiences of clients' non-attendance at alcohol services. Previous research studies were primarily quantitative studies. Some qualitative studies on non-attendance of appointments were found in non-addiction areas such as those relating to general practice, hospital outpatient or generic counselling/psychotherapy. There is a paucity of studies exploring clients' and practitioners' experiences of clients' non-attendance at alcohol treatment sessions. Therefore, research studies based on associated concepts (such as drop out, engagement, and attendance at counselling or mental health services) are also included in this literature review, even though there is a recognition that non-attendance and dropout, and alcohol support and generic counselling, are not the same concepts. The term non-attendance or DNA represents when clients do not turn up for their pre-planned and booked appointments, whereas, dropout indicates that a client has withdrawn from the service without completing their treatment.

The key aim of the search strategy was to retrieve relevant empirical papers where clients' non-attendance at alcohol or addiction services was the main focus. As recommended by Cooper (1998), relevant research papers were identified through the relevant bibliographic databases Medline, PsycInfo, PsycArticle, SocIndex, and Globalhealth

using predefined search-terms (Table 2.1) and published from inception until 2018. In order to include the maximum number of relevant papers, a range of different search terms were used. The search also included the use of an asterisk as a wildcard symbol; its use in a search-engine broadens a search by locating phrases that start with the same letters. For example, searching the word pract* would select a range of words such as practice, practise, practitioner, practitioners. The above mentioned bibliographic databases were used because most relevant research articles were available through these databases.

Table 2.1 Literature search strategy

Search criteria	Bibliographic databases	Search Terms A	Search Terms B	Search Terms C
		The following search terms used in a number of combinations (see appendix A)		
Published until 2018 Language: English Access: Full online article	Medline, PsycInfo, PsycArticle, SocIndex, and Globlhealth	alcohol*, drink*, substance*, drug*, alcohol / drug/ substance worker / practitioner*,	support*, pract*, treatment*, service*, counsel*, intervention*, help*, session*,	appointment*, attend*, engagement*, DNA*,

The search strategy was based on the preferred reporting items for systematic reviews and meta-analyses – PRISMA (Moher et al., 2009:1). Figure 2.1 demonstrates the overall search approach using a PRISMA template. It is important for any empirical research project to be able effectively demonstrate its systematic approach to a literature review such as 'what was done, what was found and the clarity of reporting' (Moher et al., 2009: 1007). Using the PRISMA template and applying the above mentioned search strategy resulted in 32 studies included in this literature review. The summary of 32 research papers is presented in the Table 2.2.

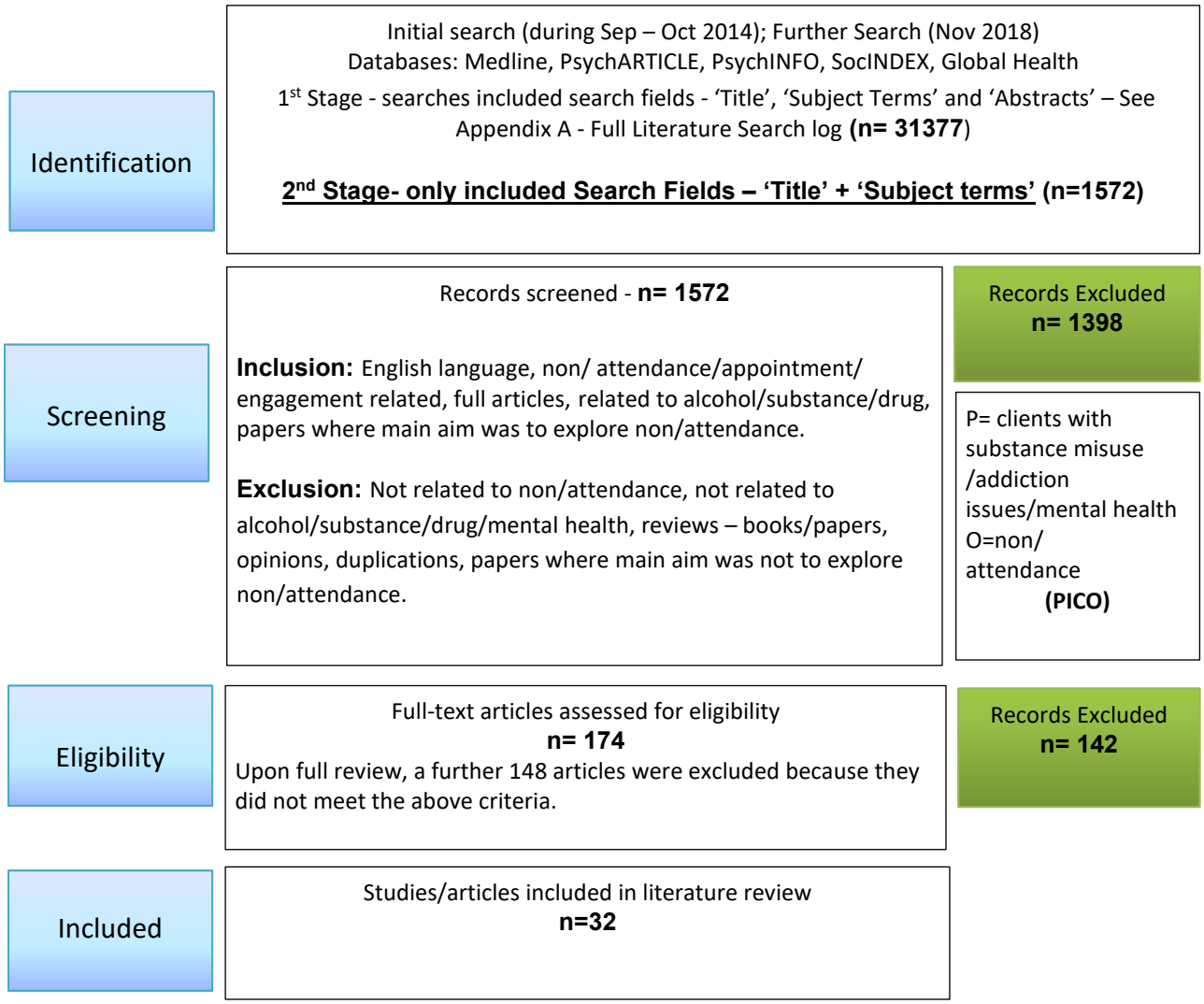


Figure 2.1: Flow chart of the literature selection process (PRISMA)

2.2 Methodologies of included studied

The selected studies (n=32) utilised a range of quantitative and qualitative research methodologies. Five papers (Stark, 1992; Wierzbicki and Pekarik, 1993; Pulford, et al., 2010; Oldham et al., 2012; Paige and Mansell, 2013) are based on a systematic review (Boland et al., 2014) of clients' non-attendance in different addiction and emotional health settings and widely reported in the research literature in relation to clients' non-attendance. Stark (1992) presented a systematic review of clients' drop out from substance 'misuse' services, based

on 12 studies – five alcohol and seven drug treatment related. Wierzbicki and Pekarik (1993) presented a meta-analysis of 125 studies on psychotherapy dropout. Oldham et al. (2012) presented a meta-analysis based on 31 randomised control trials about interventions to increase attendance at psychotherapy. Pulford et al. (2010) presented a systematic review based on 17 publications in relation to drug and alcohol treatment dropouts.

Twenty-seven empirical research studies and five research narrative review papers are included in this literature review (total n=32). The key salient descriptors of the papers in the literature review are detailed below;

Table 2.2 Methodologies and research areas of included studies

Quantitative studies	21
Qualitative studies	3
Mixed methods (QUAN and QUAL)	3
Solely alcohol focused	4
Substance misuse focused (drug and alcohol)	8
Drugs focused	5
Gambling focused	1
Emotional / mental health, psychotherapy focused	5
Generic health setting	2
Systematic reviews / meta-analysis	5

As indicated in Table 2.2, 21 included papers applied quantitative methodologies, three papers applied qualitative methodologies and three papers were based on mixed methods studies. Only four studies were solely focused on alcohol issues (Bennett, 2004; Booth and Jackson et al., 2006; Coulson et al., 2009; Webb et al., 2009). Only one study (Palmer et al., 2009) was found that explored practitioners' experiences in relation to their clients' non-attendance at their treatment appointments.

Twenty-one quantitative studies used a range of statistical analyses. This included, chi square, multi-nominal regression, logistic regression, multiple logistic regression, t-test,

survival analysis and ANOVA. Logistic regression was the most common statistical analysis, used in twelve studies. The qualitative studies utilised thematic analysis (Martin et al., 2005; Nordheim et al., 2018) and framework analysis (McCallum et al., 2015). Mixed methods studies utilised different methodologies. Palmer et al. (2009), a mixed methods study, used a focus group (qualitative) and a survey (quantitative) exploring client and clinician perspectives in relation to clients' treatment dropout. The other mixed methods study (Ball et al., 2006) used interviews (qualitative) and self-report assessments forms (quantitative) exploring reasons for dropout a drug treatment service.

2.3 Overview of included papers

Table 2.3 presents the key summary information of the selected thirty-two studies. The following information includes; authors' names, publication year, location, titles, methodologies used (quantitative, qualitative or mixed methods – quantitative and qualitative), participants, data analyses and key findings. The research papers are presented in four blocks; i) quantitative studies (n=21), ii) qualitative studies (n=3), iii) mixed methods – quantitative and qualitative (n=3), and iv) systematic reviews (n=5).

Table 2.3 Summary of key studies included in the literature review

	Author(s)	Title	Design/Method	Key findings
			Quantitative studies (n=21)	
1	Booth & Bennett (2004) UK	Factors associated with attendance for first appointments at an alcohol clinic and the effects of telephone prompting	Quantitative Participants: Consecutive non-repliers (n=100); non-attenders (n=100); attenders (n=100). Further 100 patients to study the effects of telephone prompts. Data: Appointment invitation replies and attendance record collected over 4 months.	Analysis: Multinomial regression; Logistic regression; Chi square Following patients/situations associated with better attendance rate: older patients (OR=0.97, p<0.01); shorter travelling distance to the service; shorter waiting time and administrative delay (OR=1.08, p<0.05); faster response by the patient to the appointment invitation; morning appointments (OR=0.37, p<0.05); and receiving telephone prompts (X^2=8.57, df=1, p=0.003).
2	Jackson et al. (2006) UK	Predictors of starting and remaining in treatment at a specialist alcohol clinic	Quantitative Participants: N=419, Male=272, Female=147	Analysis: Univariate analyses, multiple logistic regression

			Data: Engagement data collected post invitation letters sent in the post. Factors included in this study: demographic factors, clients' support and mental state, substance use, and clinical practice factors.	The following clients were more likely to start their treatment: older clients, who lived with others, less daily alcohol intake, no use of illegal drugs, shorter waiting times to start treatment, shorter travelling distance to the clinic, and those who made contact with the clinic prior to starting their treatment.
3	King & Canada (2004) USA	Client-related predictors of early treatment drop-out in a substance in a substance abuse clinic exclusively employing individual therapy	Quantitative Participants: N=97 – individuals referred to a substance misuse service. Data: Attendance data collected from the service	Analysis: t-tests, chi square, logistic regression Four client groups were more like to drop out: African American (X^2=15.36, df=2, p=0.003), female (X^2=10.36, df=1. P=0.001); cocaine used as the primary drug (X^2=11.46, df=5, p=0.04); and clients who were referred from outside the medical centre (X^2=9.65, df=2, p=0.008). Logistic regression analysis demonstrated two predicting factors of treatment drop-outs: gender (female) and ethnicity (African American).
4	Deane et al. (2011)	Predicting dropout in the First 3 months of 12-steps	Quantitative Participants: N=618 (f=94, m=524)	Analysis: Binary logistic regression

	Australia	residential drug and alcohol treatment in an Australian sample	Data: Following predicting variables were considered: age, gender, primary drug of concern, criminal history, psychological distress, intensity of cravings, self-efficacy to abstain, spirituality, forgiveness of self and others, and life purpose. Data collected over 14 months from 8 residential drug treatment programmes.	Two predicting factors of higher dropout rate – primary substance was a drug other than alcohol or reported greater forgiveness of self.
5	Siqueland et al. (1998) USA	Predictors of dropout from psychosocial treatment of cocaine dependence	Quantitative Participants: Multi-phase research design: sample contacted (n=1975); screened and eligible sample (n=1386); stabilisation start sample (n=675); randomised sample (n=286)	Analysis: Logistic regression; survival analysis Intake appointments – younger patients more likely to not attend. Initial stabilisation phase – patients who did not complete high school and more daily cocaine use in the past month were less likely to complete this phase (requiring 1 week of abstinence from all drugs) Treatment phase – patients were randomised assigned to three different therapy approaches – supportive-expressive therapy, psychodynamic, and cognitive therapy:

				Younger patients and presence of other mental/emotional health issues predicted dropout.
6	Wang et al. (2006) USA	"Almost There"… Why clients fail to engage in family therapy: an exploratory study	Quantitative Participants: N=30 Data: Clients who didn't engage in the family therapy were asked to complete a questionnaire. This data compared with clients who completed their therapy.	Analysis: Chi square Completers group = strong religious values, poor health history Did not engage group= Older and wealthier clients struggled with "being told the therapists were students"; clients living with more children in a family reported "lack of cooperation from family to attend" Clinic factors contributed favourably to starting therapy = a family approach to therapy, interaction with intake receptionist, flexible clinic hours. Client factors contributed to non-engagement = lack of childcare, lack of cooperation from family members, and the original problem had improved (therapy no longer needed) Therapist factors = therapist's gender

				(The paper did not clarify further the therapist factor (gender)
7	McMahon et al. (1999) USA	A comparative study of cocaine-treatment completers and dropouts	Quantitative Participants: N=27 Data: Treatment dropouts and completers compared on a number of scales – LES (Life experience survey); PSNI (Perceived support network inventory); WOC (Ways of coping); ASI (Addiction severity index)	Analysis: ANOVA Dropouts scored significantly higher on the 'accepting responsibility' scale of WOC.
8	Brown et al. (2011) USA	Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders	Quantitative Participants: N=175 Randomised trial – predicting variable assessed at two stages: at initial screen stage and then at the intake assessment stage.	Analysis: Logistic regression Following clients were less likely to complete intake assessment: males and clients with schizophrenia spectrum disorder. Clients who reported positive relationship with their families were more likely to engage in substance abuse treatment. Client who were recently arrested were more likely to dropout.
9	Prisciandaro et al. (2011)	Predictors of clinical trial dropout in individuals	Quantitative Participants: N=30	Analysis: Logistic regression

	USA	with co-occurring bipolar disorder and alcohol dependence	Following predictors of dropouts were considered: demographics, mental health diagnosis, alcohol intake, mood pathology, risk taking behaviour.	Risk taking behaviour was a significant predictor of dropout (OR=1.44, p=0.03); opiate dependency marginally predicted dropout (OR13.66, p=0.08).
10	López-Goni et al. (2011) Spain	Addiction treatment dropout: exploring patients' characteristics	Quantitative Participants: N=122 (completer = 84; dropouts= 38) Data: Three assessment scales were used: EuropASI: European version of the Addiction severity index SCL-90-R: Symptom checklist -90-revised – a psychopathological questionnaire MCMI-II: Millon clinical multiaxial inventory – to identify clinical states and personality disorders.	Analysis: Chi square or t-test; ANOVA Following patients were more likely to drop out of the treatment: unemployed and alcohol users (compared to cocaine user).
11	Vendetti et al. (2002) USA	Correlates of pre-treatment drop-out among persons with marijuana dependence	Quantitative Participants: N=813 (450 started treatment, 363 declined treatment) Variables considered: demographic characteristics, residential stability,	Analysis: Logistic regression Pre-treatment drop-out was associated with: being younger (OR=0.99, p=0.04), unmarried (OR=1.55, p=0.008), unemployed (OR=1.63,

			employment, education, referral source, and substance use factors.	p=0.02), less educated (OR=0.88, p=0.001), Asian American (OR=3.01, p=0.03).
12	McKellar, et al. (2006) USA	Pre-treatment and during treatment risk factors for dropout among patients with substance use disorders	Quantitative Participants: n=3649 (all male clients) Perception of treatment environment explored at entry stage to substance use disorder residential units	Analysis: Logistic regression The following factors predicted dropout: younger age, greater cognitive dysfunction, higher drug use, and treatment environment (low in support and high in control).
13	Xiao et al. (2017) USA	Therapist effects and the impact of therapy non-attendance	Quantitative Participants: n= 5,253 Self-report assessment of specific mental health needs	Analysis: Multilevel hierarchical regression No-shows had negative impact on client outcomes particularly if before the third session. Therapist effects were identified
14	Daniels & Jung (2009) Canada	Missed initial appointments at an outpatient forensic psychiatric clinic	Quantitative Participants: n=1630 Secondary analysis of existing dataset of two years of patients' history	Analysis: Chi square and ANOVA Two patients were more likely to attend their initial appointments – older patients and those who faced consequences related to sentencing in case of nonattendance.

15	Meier et al. (2006) UK	The role of the early therapeutic alliance in predicting drug treatment dropout	Quantitative Participants: n=187 Data: Clients and counsellors related information collected at assessment. Their average scores on WAI-S (working alliance inventory – short) used as the alliance measure.	Analysis: Regression modelling Clients with weak counsellor rated alliance dropped out at initial stages of treatment. Clients with pre-treatment crack use, better coping strategies, and secure attachment style associated with shorter retention. Older clients, better education history, and greater confidence in treatment predicted treatment completion. More experienced counsellors retained their clients for longer periods of time.
16	Ronzitti et al. (2017) UK	Gambling disorder: exploring pre-treatment and in-treatment dropout predictors. A UK study	Quantitative Participants: n=846 Data: Sociodemographic and clinical factors explored for dropouts and completers.	Analysis: Multinomial regression Pre-treatment dropouts: younger clients and drug users. In-treatment dropouts: clients with family history of gambling, being a smoker, and lower PGSI (problem gambling severity index) score.
17	Kheirkhah et al. (2016)	Prevalence, predictors and economic	Quantitative	Analysis: 2 way ANOVA

	USA	consequences of no-shows	Participants: Secondary analysis of an existing database Data: Studied non-attendance frequency and cost in 10 medical centres	Specialist clinics non-attendance: the women clinic had higher non-attendance. Geriatric clinic had lower non-attendance. Average cost of no-show per patient was $196 in 2008.
18	Green et al. (2002) USA	Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program.	Quantitative Participants: n= 293 Gender difference studied at three stages – treatment initiation, completion, and time spent in treatment.	Analysis: Logistic regression No gender difference regarding treatment initiation, completion, and time spent in treatment. Factors predicting these outcomes differed in both genders markedly.
19	Babbar et al. (2018) USA	Therapist turnover and client non-attendance	Quantitative Participants: clients n=76; practitioners n=30. Clients who attended a mental health service Data: clients demographics, attendance history and practitioners turnover history considered	Analysis: Mixed-effect regression 86% clients more likely to miss a future planned therapy session after their practitioner left the service.
20	Webb et al. (2009) UK	Care pathways to in-patient alcohol detoxification and their	Quantitative Participants: Clients n=6,745	Analysis: Multiple logistic regression Predictive factors of treatment completion: older age, females, in employment, and

		effects on predictors of treatment completion	Data: In-patient detoxification treatment completion data from Jan 1995 – Mar 2003	referred via a gate-keeping admission process (where a gate-keeper professional service referred a client for in-patient detoxification).
21	Weisner et al. (2001) USA	Factors affecting the initiation of substance abuse treatment in managed care	Quantitative Participants: Clients n= 1207, over 18 years old, 75% males, 28% ethnic minority clients. Data: Structured interviews and treatment registration data	Analysis: Bivariate analysis and hierarchical logistic regression For alcohol dependent clients – women were more like to attend their initial sessions than men.
			Qualitative studies (n=3)	
22	Martin et al. (2005) UK	Non-attendance in primary care: the views of patients and practices on its causes, impact and solutions	Qualitative Participants: n=37 (24 patients; 7 GPs, 1 nurse, 5 receptionist) Semi-structured interviews	Analysis: Thematic analysis Key themes: forgetfulness, competing priorities (for patients), booking system, differing attitudes towards non-attendance between different groups, lack of empathic relationship with GPs leading to nonattendance.
23	McCallum, et al. (2015)	'I'm a sick person, not a bad person': patient	Qualitative	Analysis: Framework

	Australia	experience of treatments for alcohol use disorder	Participants: n=34 (males 22, females 12; average age 44 years; White 33) Data: Semi-structures interviews	Five themes identified relating to clients' satisfaction: perceived effectiveness of treatment, therapeutic relationship, specialised but holistic support, client autonomy, and treatment continuity.
24	Nordheim at al. (2018) Norway	Young adults' reasons for dropout from residential substance use disorder treatment	Qualitative Participants: n=15 (females (4) and males (11); age 19-29 years) Data: Semi-structured interviews with clients who dropped out of residential substance use treatment centre.	Analysis: Thematic Dropout had two functions; a break from treatment/stopping treatment and reducing treatment intensity. Four themes were reported in relation to participants' reasons for dropout; i. craving (substance craving as a trigger to dropout), ii. negative emotions (experiencing negative emotions during treatment partly due to lack of use of substance which was used to deal with emotional pain in the past), iii. personal contact (lack of contact with staff; lack of therapeutic relationship) and iv. activity (lack of engaging activities).

				Following suggestions were made the participants to improve their engagement; closer contact with staff, more engaging activities, and effective post treatment follow-up.
Mixed methods: Quantitative and Qualitative (n=3)				
25	Coulson et al. (2009) Australia	Client-reported reasons for non-engagement in drug and alcohol treatment	Mixed methods: Quantitative and Qualitative Participants: Clients who missed a first or second appointment Data: Semi-structured telephone interviews and a questionnaire (Likert scale based) covering: therapeutic alliance, service satisfaction, perceived impact of substance use, and previous treatment experiences. Demographics from client service database. Total group (n= 163); Treatment engaged (n=97); Missed appointment (n= 66)	Analysis: Chi square; Mann-Whitney *U*-test; Content analysis Client-reported reasons: extraneous factors, service shortcoming, no further need for service, and motivational ambivalence. The following clients were more likely to miss their appointments: male, unmarried, and polysubstance users.

26	Ball et al. (2006) USA	Reasons for dropout from drug abuse treatment: symptoms, personality, and motivation	Mixed methods: Quantitative and Qualitative Participants: N=24 Data: Interviews and self-report assessments from client who ended their drug treatment prematurely. Bespoke self-report questionnaire RLTQ (Reasons for leaving treatment questionnaire) was developed based on seven categories; problem severity, logistical problems, staff conflict, motivational inconsistencies, programme expectations, boundary concerns, and outside influences. Other self-report scales included – ASI (addiction severity index), URICA (university of Rhode Island change assessment), and SNAP (schedule for non-adaptive and adaptive personality).	Analysis: t-test, Pearson correlation RLTQ – No demographic factors (age, gender, race, education, employment, living situation, referral source, family problems/history) were related to the RLTQ except marital status. Marital status (never married) related to more problem severity for both men and women ($t(22)=2.5$, $p<0.02$), motivational inconsistencies ($t(22)=3$, $p<0.01$), logistical problems ($t(22)=2.39$, $p<0.03$), and outside influences ($t(22)=2.21$, $p<0.04$). Reasons for premature termination of treatment: Client motivation, maladaptive personality functioning and conflicts with staff. Concerns about privacy and boundary issues were also reported reasons by clients.

27	Palmer et al. (2009) USA	Substance user treatment dropout from client and clinician perspectives: a pilot study	Mixed methods: Quantitative and Qualitative Participants: Clinicians (n=44); clients (n=22) Focus group (qualitative) and survey (quantitative)	Analysis: ANOVA Reasons for dropouts: heavy drug and alcohol use, transportation or financial problems, and ambivalence about abstinence. Focus groups findings: Clinicians reported - client motivation and staff connections; clients reported – social support and staff connection issues attributed to early dropouts.
			Systematic reviews (n=5)	
28	Paige & Mansell (2013) UK	To attend or not attend? A critical review of the factors impacting on initial appointment attendance from an approach-avoidance perspective	Mental health literature review to explore demographic and psychological factors in relation to clients' attendance	Review Mixed findings regarding engagement vs avoidance depending on interplay of timing, the client and their service context.
29	Wierzbicki & Pekarik (1993) USA	A meta-analysis of psychotherapy dropout	Data: Meta-analysis of 125 studies on psychotherapy dropout.	Analysis: Effect size (d) Mean dropout rate = 46.86% The term dropout defined differently.

				Lower dropout rate when dropout defined as termination. Three demographic variable shown significant effect sizes: ethnicity (African-American and other minorities), education (less educated), and income (lower income groups)
30	Stark (1992) USA	Dropping out of substance abuse treatment: a clinically oriented review	Systematic review based on 12 studies (5 – alcohol treatment related; 7 – drug treatment related).	Higher drop-out rate (50%) in the first month. Demographics: younger clients, African-American clients and females were more likely to drop-out. Social factors: social isolation and lower socioeconomic status were more likely to drop-out. Per-treatment criminal history linked to early drop-outs. Factors suggested to improve clients' engagements: closer location of the service, smaller local clinics, and staff availability.
31	Pulford et al (2010)	Responding to treatment dropout: a review of	Systematic review	Motivational strategies more likely to improve clients' retention.

	New Zealand	controlled trials and suggested future directions	Participants: Systematic review - 17 publications (alcohol and other drug treatment settings)	
32	Oldham et al. (2012) UK	Interventions to increase attendance at psychotherapy: a meta-analysis of randomised controlled trials	Meta-analysis 31 randomized controlled trials included (N=4,422)	Analysis: Effect size (d) Following strategies demonstrated effectiveness: choice of appointment time, choice of therapist, motivational interventions, preparation for psychotherapy, informational interventions, attendance reminders, and case management.

The key findings of the above mentioned studies (Table 2.2) can be divided into three broad categories in relation to factors associated with clients' non-attendance. The three categories are client demographics, client characteristics and psychological factors, and service delivery factors. In the next section, I will present the summary of the key findings of the studies included in this literature review before discussing them further in section 2.4.

2.4 Summary of the key findings

The following Table 2.4 presents the summary of the key findings (Table 2.3);

Table 2.4 Factors associated with poor attendance rate

Category	Factors related to non-attendance as reported in selected studies (Table 2.3)
Client demographics	Male, unmarried, younger clients, African American, Asian American, cocaine as the primary drug, primary substance was a drug instead of alcohol, less educated, financial issues, no children. Some studies reported contrary findings. This included; female, no demographic factors (age, gender, race, education, employment, living situation, referral source, family problems/history) linked to DNA, and alcohol users instead of cocaine users more likely to DNA.
Client characteristics and psychological factors	Polysubstance users, opiate dependency, comorbidity mental health issues, lack of support from family, recent offending history, greater cognitive dysfunction, extraneous factors, motivational ambivalence, greater forgiveness of self, maladaptive personality functioning, better coping strategies, risk taking behaviour, abstinence ambivalence, secure attachment style, smoker, forgetfulness, competing priorities, cravings, negative emotions, social isolation.

Service delivery factors	No further need for service, service shortcomings, longer waiting times, administrative delays, longer travelling distance/transportation issues, afternoon appointments, conflict with staff, concerns about privacy and boundary issues, treatment environment (low in support and high in control), lack of: choice of appointment time, therapist, information on interventions, attendance reminders and case management approach, weak client-practitioner working alliance, newly trained practitioners, lack of engaging activities, staff availability, lack of treatment continuity, lack of client autonomy

Table 2.4 presented the key factors related to clients' non-attendance and dropouts from addiction and mental health services based on quantitative, qualitative, and mixed methods studies mentioned in Table 2.3. The main purpose of Table 2.4 was to summarise the key findings of the above mentioned 32 studies (Table 2.3) in order to present a vast amount of data in a succinct manner. Previous studies mainly attributed clients' non-attendance and dropouts to client-related or service-related factors. It is clear that there was a lack of focus on exploring practitioners' experiences in relation to their clients' non-attendance. There was no previous study found during this literature search that explored clients' non-attendance at a community-based alcohol service using mixed methods (quantitative and qualitative) methodology and incorporating both clients and practitioners' perspectives. Next, I will critically discuss the studies included in this review.

2.5 Non-attendance at treatment

Clients' non-attendance is a prevalent issue in substance misuse treatment services (Stark, 1992) and it negatively impacts the treatment outcomes and services' financial resources (Coulson, et al., 2009). Most behaviour changing therapies rely on clients' attendance and engagement with treatment services and therefore non-attendance jeopardises their treatment goals. According to a *Guardian* newspaper report in January 2018, non-attendance at appointments costed the NHS £1bn in 2017 (Slawson, 2018). Martin et al. (2005) reported the estimated cost of over £150m per year to GPs for patients'

non-attendance. The cost of non-attendance impacts overall service delivery, particularly in such times of austerity where limited funding is available to deliver services in the UK. Clients' non-attendance at planned appointments impacts the service delivery provision in a number of ways such as; additional staff time spent on administration and client follow up processes, and additional funding cut implications because many UK based services have numbers in treatment and low dropout rates as their commissioning targets. Non-attendance at treatment sessions also further exacerbates clients' presenting issues and underlying problems (Carpenter et al., 1981; Larsen et al., 1983; Lowman et al., 1984). The exacerbating financial and health costs affecting the health-care system continue to become a burden for substance addiction treatment programs (King and Canada, 2004).

In the next section, I will critically discuss the findings from the studies mentioned in Table 2.2. This discussion will be presented under five broad headings;

- Client-related factors
- Service-related factors
- Therapeutic relationship
- Retention in treatment
- Improving attendance

2.6 Client-related factors

Previous research studies highlight that client demographics such as, age, ethnicity and sex are linked to their non-attendance. A number of studies have mentioned that client demographics and extraneous variables have a significant part to play in the retention of clients in substance misuse services (King and Canada, 2004; Coulson et al., 2009; Palmer et al., 2009; Deane et al., 2011). Factors such as younger age, less education, unemployment, and having dependent children in their care, have been suggested to increase the likelihood of DNA rates (Siqueland et al., 1998; King and Canada, 2004). Such demographic variables are not readily modifiable but can be screened as early as possible in order to support clients in overcoming such barriers to remain in treatment. If the finance and resources for the service provider were available, treatment programmes could be adapted to address these barriers.

Ethnicity and gender have also been noted to have an effect on the likelihood of DNA in treatment programmes (Arfken et al., 2001; King and Canada, 2004). Being female, according to these studies, was a significant predictor of drop-out rates. King and Canada (2004) found a 61% drop-out among females in one substance abuse treatment programme in comparison to 26% of males. These results, however, need to be treated with caution, as there was more than double the number of males than females in the treatment programme. On the contrary, Weisner et al. (2001) suggest that women were more likely to start their addiction treatment and attend their initial meeting.

Looking at ethnicity and DNA, Mccaul et al. (2001) found African American clients were more likely to drop out of treatment programmes than their white counterparts. King and Canada (2004) reported that African American clients were five times more likely to drop out of addiction treatment than white clients. King and Canada (2004), a North American quantitative research (n=97), explored client-related predictors of early treatment drop outs in an addiction clinic. King and Canada (2004) considered the following client-related predicting factors; age, gender, education, ethnicity, marital status, employment, caring for dependent child, and referral source. Ethnic minority communities are significantly less likely to seek treatment and advice for drinking problems, keeping them hidden from their strict culture (Hurcombe et al., 2010). Mennis and Stahler (2016), a North American quantitative study, explored racial disparity in addiction treatment completion based on logistic regression analysis on a large dataset (n=416,224 – outpatient treatment discharges). They reported that African American were more likely to drop out from addiction treatment compared to white clients and recommended that addiction treatment provider should offer culturally appropriate interventions (Mennis and Stahler, 2016).

Booth and Bennett (2004:269) reported a range of factors associated with increased level of attendance at an alcohol clinic such as ‘clients' older age, shorter travelling distance, shorter waiting time and administrative delay, faster response by the client to the appointment invitation, and morning appointments’.

Booth and Bennett (2004), conducted a UK-based study, designed to explore client-related and service-related variables in relation to clients’ attendance at first appointment at an alcohol treatment service. They wanted to assess the efficacy of telephone prompts

for appointments on clients' attendance. The sample size consisted of 300 clients' attendance records including 100 consecutive non-repliers of appointment invitations, 100 non-attenders and 100 attenders over a 4-month period. A multi-nominal logistic regression analysis was used to explore predicting factors of clients' non-attendance. Booth and Bennett (2004) reported that variables like the older age of clients, morning appointments, less travelling distance and shorter administrative delays predicted good attendance rates. Booth and Bennett (2004) included a range of client and service-related variables in their study such as, sex, age, referral source, administrative response to referrals in days, appointment day and appointment time (a.m./p.m.). The absence of other useful variables such as ethnicity and relationship status is not explained in their research paper. It should be noted that that the clients' drinking levels at the time of referral and their referral sources were not considered in this study. In addition, the 'non-repliers (n=100)' never accepted the treatment, thus their absence should not have been considered as 'non-attendance'. The finding of this study should therefore be interpreted with caution. Booth and Bennett (2004) raised an important point in their concluding remarks, suggesting that services might not be able to cope with the increased demand in the case of increased attendance rates. Booth and Bennett's (2004) findings were supported by many other studies (Jackson et al., 2006; Coulson, et al., 2009) particularly in relation to age, distance from the clinic and prompt responses from services as significantly important predicting factors of clients' attendance at alcohol or substance misuse treatment services.

Jackson et al. (2006), in a UK-based study, set out to explore predicting factors of clients' attendance at a specialist alcohol treatment outpatient clinic. Jackson et al. (2006) studied 419 clients' data (272 males, 147 females) at a specialist alcohol clinic over a 2-year period. Their primary focus was to look at the number of clients who started treatment following assessment, that is, started their treatment post assessment session/s. The data included clients' demographics, mental health, clients' support network, substance use history and service-related factors such as; administrative response time, type of treatment, clinic location and referrer details. Clients' demographics included; age, sex, employment status, relationship status and living status. Jackson et al. (2006) used univariate and multiple logistic regression analyses and reported that variables such as; older age, less alcohol consumption, living with others, no illegal drug use, shorter waiting time between

assessment and first treatment session and shorter distance to clinic predicted a higher attendance rate. They suggested the following steps to enhance clients' engagement; motivational work during assessment, phone contact before the start of treatment to remind them and the offer of local satellite clinics. This means that the service providers can improve their clients' attendance rate by reducing administrative delays, offering satellite clinics to improve accessibility and supporting clients to further develop their support network. It should be noted, in their study, that clients were given four treatment options (6-week structured programmes, unstructured evening groups, and 3-week in-patient structure programme) to choose after the assessment, however, different treatment options were not considered as possible predicting factors for clients' engagement. For example, attending a 3-week inpatient group was significantly different from attending evening groups. Clarkson et al. (2006) reported that sex is not a significant predicting factor of clients' non-attendance, which is inconsistent with Booth & Bennett (2004). Similar to Booth and Bennett (2004), Clarkson et al. also did not include ethnicity and no rationale is provided for missing out this crucial demographic factor. It could be argued this absence of ethnicity in both studies (Booth & Bennett, 2004; Jackson et al., 2006) suggests a notion of a colour-blindness by researchers.

Age (older), distance from the service (shorter), waiting times (shorter), appointment times (morning), support system (family and social networks) and stable life style (low drinking) are some of the main factors for higher attendance rate (Booth and Bennett, 2004). Both of the above mentioned studies (Booth and Bennett, 2004; Jackson, et al., 2006) are quantitative research, therefore, lack details of the context of their participants and restrictive in explaining the reasons for the clients' non-attendance (Balnaves and Caputi, 2001). For example, there was no narrative available to explain why young people were more likely to not attend? This highlights the significance of mixed methods research methodology in order to have a greater understanding of the phenomenon.

Webb et al. (2009), in a UK-based study, set out to explore factors predicting treatment completion in an in-patient detoxification treatment unit and to assess the impact of a treatment referral or gate-keeper's role. Over an 8-year period, 6,745 client admission records were included in this study and a multiple logistic regression analysis was used to determine predictive variables (Webb et al., 2009). They reported that variables

such as; white females over 45 yrs old, being in employment, and referred by a gate-keeper professional, predicted successful completion of the treatment. The study focused on 'in-patient' detoxification completion rates and therefore the issue of non-attendance was not directly addressed, however, non-attendance and treatment withdrawal are comparable phenomena. This study mainly supports the findings of the above-mentioned studies suggesting that older clients were more likely to complete their treatment. It should be noted that this study was based on in-patient treatment setting, therefore, their findings should be interpreted with caution. This is because a number of factors that could negatively impact clients' engagement were not relevant in this study such as travelling distance, financial issues, time of the session, and transport problems.

Hamilton et al. (2002) sent a questionnaire survey to 493 non-attenders from five general practices in Exeter, UK. The questionnaire addressed possible reasons for non-attendance and possible steps to reduce further non-attendance. Hamilton et al. (2002) reported the following key findings; females missed more appointments (56%), patients between 25 to 44 years' age range missed their appointments more than any other age group and clients' forgetfulness was the main reason for non-attendance reported by patients. Neal et al. (2005) suggest that being unwell, where the service was no longer needed and forgetfulness were the main reasons for missed appointments in general practice in the UK. Their study included postal questionnaire survey and medical notes reviews of 386 patients who missed their appointments. One hundred and twenty-two of 386 non-attenders returned their questionnaires and 40% (of 122) reported forgetfulness as their main reason for non-attendance. Other responses included 'misunderstandings and mistakes, illness or personal circumstances, and other commitments' (Neal et al., 2005: 3). Both of the above mentioned studies (Hamilton et al., 2002; Neal et al., 2005) were located in the primary care setting (general practice) and relied on quantitative methodologies, therefore, lacked any in-depth understanding of clients' narratives and reasons for non-attendance. This highlights the significance of undertaking a mixed methods research to have a greater understanding of clients' issues in relation to treatment engagement.

It is important to understand the reasons for DNA in order to ensure better attendance rates at alcohol treatment programmes. Factors like, lack of motivation, staff disagreement or conflict, external influences and inconsistency with programme

expectations, are associated with non-attendance (Ball et al., 2006). Coulson et al. (2009) found four separate categories for DNA in substance misuse treatment programmes. These consisted of extraneous factors (e.g. work commitments, illness, social and logistical issues), perceived shortcomings, no further need for service, and motivational ambivalence. Extraneous variables were found to be most significant, explaining 50% of the reasons for DNA.

Extraneous variables have also been shown to have an effect on DNA rates within the first few sessions of alcohol treatment. These variables include; transportation and financial problems, work commitments, and social and logistical issues (Palmer et al., 2009; Coulson et al., 2009). Weisner et al. (2001) highlight external and individual factors related to attendance at addiction treatment sessions. External factors include pressure from family, work-colleagues and the criminal justice system whereas individual factors include the individual's perception of significance of treatment, treatment goals and readiness to change.

As well as extraneous variables for non-attendance, previous research has focused on psychosocial reasons related to DNA in treatment programmes. Psychosocial reasons such as referral sources, financial issues, social support, and working alliance with practitioner impact on clients' engagement and it is important practitioners appropriate respond to these issues in order to facilitate clients' engagement Palmer et al., 2009). In addition, psychosocial factors such as a lack of coping strategies, lack of motivation, and a lack of social support have been hypothesised to relate to higher DNA in clients (Palmer et al., 2009).

Hampton-Robb et al. (2003) report 16% to 67% DNA rates at first psychotherapy sessions based on 13 previous studies from 1963 to 1995 in the USA. They included the following studies;

- Allan (1988) N=197, DNA 26%
- Campbell et al. (1991) N-236, DNA 20%
- Carpenter et al. (1981) N=1,106, DNA 31%
- Festinger et al. (1995), N=235, DNA 56%
- Folkins et al. (1980), N=150, DNA 39%
- Gould et al. (1970) N=152, DNA 16%
- Grunebaum et al. (1996) N=281, DNA 38%
- Kluger and Karras (1983) N=25, DNA 56%
- Lowman et al. (1984) N=2,358, DNA 67%
- Overall and Aronson (1963) N=40, DNA 57%
- Raynes and Warren (1971) N= 738, DNA 40%
- Swenson and Pekarik (1988) N=30, DNA 43%
  Yamamoto and Goin (1966) N=200, DNA 35%

Waiting times, presenting issues, history of non-attendance, previous treatment experiences, and distance from the service were the main factors for clients' non-attendance reported in those studies (Hampton-Robb et al., 2003). It should be noted that most of the above mentioned studies were not specific to addiction treatment and relied on small sample size, therefore, their generalizability and findings should be interpreted with caution and this is what one of my research strands will address in this study.

Vogel et al. (2007), based on their literature review, present a list of five 'avoidance factors' in the help-seeking processes; social stigma, treatment fears, fear of emotions, anticipated usefulness and risks, and self-disclosure. The treatment providers should consider these emotional barriers with an empathic responsiveness in order to improve clients' engagement. It is important that the practitioners are trained to address clients' real and imaginary fears about treatment and change.

In another North American study five predictors of non-attendance at a university psychiatric outpatient clinic were identified; age (younger), ethnicity (Hispanic), class (poor family background), not taking psychotropic medication and having health insurance (Kruse et al., 2002). They further suggest that non-attendance can negatively impact the effectiveness of the care provided and efficiency of resource provision (Kruse et al., 2002). A meta-analysis of psychotherapy drop-out rates by Wierzbicki and Pekarik (1993) shows an average 47% dropout rate. Ethnicity (minority groups), educational background (less educated) and finances (low income) were the three key demographic factors linked with dropout. Both of the above mentioned studies highlighted low socio-economic factors as predictors of non-attendance. It is important that the treatment providers should address the negative impact of financial issues in relation to travelling costs associated with appointment attendance.

Forgetfulness, client demographics and service availability negatively impact clients' attendance at health services (Akter et al., 2014). The above noted Australian research findings can be applicable to the UK as issues such as forgetfulness, cost and service availability have been addressed to a reasonable extent. Appointment reminding systems are now commonly used within the UK health sector.

The existing literature has mainly looked at the issues of non-attendance at substance misuse services through the particular lenses of demographic, psychosocial and clinical issues. In addition, the findings of the generic emotional and physical health focused studies (non-addiction) should be interpreted with caution in relation to understanding clients' non-attendance at alcohol services. I would argue that further research in relation to non-attendance at alcohol treatment services would be enhanced and deepened through a consideration of relational factors – how practitioners and clients relate to each other in the counselling room. In the next section, I will explore service-related factors in relation to clients' non-attendance.

2.7 Service-related factors

There are many service-related factors linked with clients' non-attendance such as waiting times between referrals and assessment (Claus and Kindleberger, 2002), between assessment and treatment (Sebastian et al., 2012) and a poor working alliance (Meier et al., 2005). Coulson et al. (2009) state that the service environment, administrative functions, flexibility regarding appointments and staff attitudes are some of the key contributing service-related factors with regard to non-attendance in addiction services. The therapeutic relationship or therapeutic alliance is considered as one of the key predictors of engagement and retention in drug treatment (Meier et al., 2005).

Coulson et al. (2009), in an Australian study, set out to explore client reported reasons for their non-attendance at a drug and alcohol service. Coulson et al. (2009) compared client characteristics of those who attended their first or second appointments and those who missed those appointments during a four-month period. They conducted semi-structured telephone-based interviews and completed Likert scale questionnaires with those who missed their appointments. Client demographics and clinical variables were collected and compared for both groups – attenders (n=97) and non-attenders (n=66). Coulson et al. (2009) reported that 50% of the non-attenders stated extraneous factors were the main reasons of their non-attendance. These extraneous factors included; forgetfulness, other commitments, illness, transport issues and housing problems (Coulson et al., 2009). It could be argued that people may just be following the social norms of politeness and not saying 'I did not like my counsellor' or there were 'service-related'

factors. Approximately 30% non-attenders reported service shortcomings (such as poor communication, inflexible opening hours, slow administrative processes, specific staff issues, did not like the physical location and negative impression of service), whereas 16% reported the service was no longer needed and 4% reported motivational ambivalence as their reasons for non-attendance (Coulson et al., 2009). In relation to clients' demographics, people who were male, unmarried, living with parents and poly drug users were more likely to miss their appointment (Coulson, et al., 2009). Only 4% of clients reported motivational ambivalence as their main reason for non-attendance whereas the majority of clients reported logistical and practical issues as their main reasons for non-attendance. This study presented contrary findings to an extensively reported notion of client's motivation to change in relation to addiction and attendance at treatment (Gilder, et al., 2017). Due to very low numbers of ethnic minority participants in this study (3.7%) it is not possible to explore any impact of ethnic background on attendance history.

Lacy et al. (2002) conducted semi-structured interviews with 34 patients attending an outpatient health clinic in the USA. Participants' demographics were; 32 females and 3 males, age range 22-78 years, 58% African American, 37% White American, and 4% Hispanic American (25% participants did not identify their race). Lacy et al. (2002) identified three patient-reported issues with their non-attendance; negative emotional state, perceived disrespect (clients' perception of services/practitioners) and a difficult appointment system. They also recommended that long waiting times and patients' experiences of using health services need to be addressed in order to reduce non-attendance (Lacy et al., 2002).

Previous research has demonstrated that shorter waiting times between phone contact and the first meeting results in higher attendance rates at substance misuse services (Stasiewicz and Stalker, 1999). Stasiewicz and Stalker (1999) conducted a study where they randomly assigned clients (n=128) to four groups; Group 1 were offered a first meeting after the phone contact within 48 hours, Group 2, 3, 4 were scheduled after 48 hours or more. Group 2 received a reminder call 24 hours prior to their meeting, Group 3 received an appointment card and service brochure and Group 4 received no communication. The results indicated that the Group 1 clients had the higher attendance rate. This study suggests that early appointments after the referral are more effective indicators of attendance rate (Stasiewicz and Stalker, 1999).

Where there are a number of research studies in this area, there is no consistent message for the service provision as different studies have explored a range of issues in relation to clients' attendance and engagement. In my view, methodological issues remain the main challenge in the field. Paige and Manswell (2013) presented a critical review of the factors impacting on initial appointment attendance at psychological services and reported that there were conflicting findings from different research studies. They summarised a number of methodological issues that led to contradictory findings in the previous studies, that is, 'poor data collection, poor methods of classifying terminated patients, infrequent use of standardised measures and variations in clinic populations and procedures' (Johannsson and Ekland, 2006, as cited in Paige and Mansell, 2013:76). Paige and Manswell's (2013) findings were mainly consistent with previous research studies (Stark, 1992, Hunt and Eisenberg, 2010) which suggested that service gaps or service-related factors and individual factors were reported as the key predictors of clients' attendance at initial appointments.

In this section, I explored a range of service-related factors in relation to clients' attendance. The above discussion highlights that more accessible, flexible and responsive treatment services are essential to improve clients' attendance and engagement. In the next section, I will discuss the significance of the therapeutic relationship in clients' engagement with services.

2.8 Therapeutic relationship

An important psychosocial aspect relating to DNAs is the therapeutic relationship between the client and the practitioner, and the level of shared decision-making between them. In Deegan and Drake's (2006) view, this requires an effective working alliance in order to support the client to manage presenting symptoms and mutually develop solutions to assist meaningful change (Deegan and Drake, 2006). Previous research has shown a link between an effective therapeutic relationship and treatment retention. On the other hand, a lack of therapeutic relationship between client and clinician has been hypothesised to have an adverse effect on treatment engagement, leading to DNAs due to a lack of connection with practitioners and the therapy programme (Palmer et al., 2009). Health-care professionals (HCPs) find it difficult to understand why clients DNA, when they have made

the initial decision to get help for their addiction problem (Palmer et al., 2009). Therefore, it is important to have effective quantitative and qualitative research studies in order to have greater understanding of clients' psychological reasons for non-attendance.

A therapeutic alliance or relationship is a significant predictor of continuation of treatment and retention in therapy services including drugs services (Meier et al., 2005). The relationship between the client and the clinician has a significant impact on the progress made within the service, as well as the progress they make in their addiction recovery. 'Feeling comfortable' with a HCP (health care practitioner) was found to have a significant impact on the clients' engagement in treatment programmes in substance abuse services, and showed significant improvements in completion of the programme at 3 and 12 month follow ups (Orford et al., 2009).

Clarkson (2003) presents five interrelated aspects of therapeutic relationships; working alliance, transference/countertransference, reparative, person-to-person, and transpersonal. The working alliance offers an ethical, legal and psychological contract between a practitioner and client. The transferential relationship involves unconscious projections onto and into the therapeutic relationship and the reparative relationship involves a practitioner's conscious attempts to offer a reparative relationship in order to address unhelpful historic relational encounters. The person-to-person therapeutic relationship focuses on the dialogical or 'I-thou' aspects (Yontef, 1993), that is, an authentic meeting between a practitioner and client.

As mentioned above, a working alliance offers the solid ground for practitioner and client to develop their work together. Legal and ethical aspects cover issues such as confidentiality, privacy, data protection protocols including general data protection regulations (GDPR), nature of the work, agreement on therapeutic goals, financial and appointment related matters (BACP, 2018). Psychological contracting involves both parties (the practitioner and client) committing to work together in the service of the clients' presenting issues and mutually agreed therapeutic outcomes (Clarkson, 2003). The working alliance is a subjective experience of collaboration, cooperation, trust and a commitment to work together between a practitioner and client (Horvath, 2018). Rogers (1957) pioneered person-centred therapy in 1940s/1950s and presented a model of conditions for effective

therapeutic engagement. These therapist-offered conditions were based on three core conditions; empathy, unconditional positive regard and congruence (Mearn et al., 2013; Gelso and Carter, 1994).

Empathy, the practitioner's ability to understand the client's perspectives including thoughts, emotions and feelings, is considered as the single most important therapist-based relational attitude in the counselling and psychotherapy field (Rogers, 1980; Blatt et al., 1996). Elliot et al. (2019) present a working definition of empathy,

> '1. Empathy is interpersonal and unidirectional, provided by one person to another person. 2. Empathy is conceptualised primarily as an ability or capacity and only occasionally as an action. 3. Empathy involves a range of related mental abilities/ actions, including; a. Primarily: understanding the other person's feelings, perspectives, experiences, or motivations, b. But also: awareness of, appreciation of, or sensitivity to the other person, c. Achieved via: active entry into the other's experience, described variously in terms of vicariousness, imagination, sharing, or identification'. (Elliot et al., 2019: 246)

Extensive research studies support the strong relationship between a working alliance or therapeutic relationship and therapeutic outcomes. Horvath et al. (2011) present a research synthesis based on 200 studies, 190 data sources and covering approximately 14,000 treatments. They confirm their previous findings, such as, Horvath and Bedi (2002) and Duff and Bedi (2010); that is, there is a strong relationship between the working alliance and therapeutic outcomes. Fluckiger et al. (2020) report that a working alliance is positively related to therapeutic outcomes and that this association is above and beyond the 'clients' intake characteristics and treatment processes' (Fluckiger et al., 2020:1). Fluckiger et al. (2020) present meta-analysis based on 60 independent samples of empirical studies. They claim, 'our results provide robust empirical evidence for the assertion that the alliance-outcome association is an independent process-based factor' (Fluckiger et al., 2020:1).

Despite extensive empirical research evidence in favour of the importance of the therapeutic relationship to treatment outcomes, the therapeutic services commissioned in the United Kingdom and the National Institute of Clinical Excellence have continued to ignore this crucial aspect in their service commissioning contracts and treatment guidelines

(Paley and Lawton, 2001; Jackson and Rizq, 2018). For example, NICE disproportionately promote and recommend cognitive behaviour based therapeutic modalities instead of therapeutic relationship-focused approaches such as gestalt therapy and person-centred therapy.

As stated above, extensive research has been done on the role of the working alliance in the counselling and psychotherapy field. There is, however, a scarcity of research on the working alliance in relation to alcohol treatment. Cook et al. (2015) undertook a longitudinal study exploring predictors of the working alliance and the impact of the working alliance on post treatment motivation and treatment outcomes. They used a Working Alliance Inventory (WAI) to assess clients (n=173) and practitioners' perception of the working alliance at the start of treatment and after nine months (Cook et al., 2015). Cook et al. (2015) reported that clients' perceptions of a strong working alliance predicted successful treatment outcomes, positively impacted drinking behaviour during treatment and post treatment motivation to change. Brorson et al. (2013) recommended continuous monitoring of working alliance based on their systematic review of risk associated with early drop-outs from addiction treatment, comprised of 122 studies including 199,331 participants.

In brief, effective therapeutic relationships between practitioners and clients are essential for clients' attendance, engagement and overall treatment outcomes. It is important that service providers pay specific attention to their staff members' skills and competencies to offer meaningful relational interventions to their clients.

Next, I will discuss the issues related to clients' retention in treatment.

2.9 Retention in treatment

A further theme in the existing evidence relates to factors affecting retention in treatment. Most of the previous research literature in this area focuses on the negative reasons for DNAs, however, there are also some positive reasons reported. Positive reasons include; leaving treatment as a satisfied customer, having obtained sufficient help, and feeling that they no longer needed the treatment (Wierzbicki and Pekarik, 1993; Coulson et al., 2009).

Gray et al. (2014) explored the challenges and solutions to the provision of alcohol treatment for Aboriginal Australians in their thematic review of five studies. They highlighted a number of suggestions in order to enhance Aboriginal Australian clients' accessibility to alcohol treatment services such as; recognising and responding to cultural differences, adapting mainstream treatment interventions to meet the needs to Aboriginal clients, appropriate availability of resources and funding for agencies, and multidisciplinary partnerships between agencies based on trust and respect (Gray et al., 2014).

When looking at the literature on reasons for non-attendance, positive factors and variables have come to light which suggest various reasons that clients may be more likely to continue treatment. Dearing et al. (2005) found 42% of the variance for retention to treatment programmes was explained by having a positive relationship between clinician and client, positive expectations about therapy, and client satisfaction of service. These are supported by findings in other studies, for example, Meier et al. (2005: 304) who have stated that increased 'motivation, treatment readiness and positive previous treatment experiences' are all indicators of treatment retention.

Factors such as higher determination, increased commitment and an active decision to change are indicative of retention and have a positive impact over a 12 month follow up (Orford et al., 2009). All of these factors should be taken into consideration and measured when a client first attends a treatment programme, to further enhance the likelihood of clients' attendance and engagement in their treatment.

Individual factors and barriers to adherence should be addressed by the treatment providers to help clients overcome such issues. Simple tasks for this change can be seen by Lefforge et al. (2007), who found reminder letters about appointments and telephone prompting, not only improved the relationship between the client and the clinician, but also improved attendance against previously stated reasons such as forgetting about subsequent appointments.

Certain levels of commitment and eliciting agreements between clients and clinicians were also found to have a positive impact of the levels of attendance (Lefforge et al., 2007; Abraham and Michie, 2008). These showed soliciting a client's commitment to the programme and to the appointment, and resolving obstacles that would make it less likely

for the client to be able to attend, have shown to be simple steps that create a significant change in the attendance rates and completion of the treatment programme. Early DNAs from substance treatment programmes continue to be a widespread problem, limiting the effectiveness of the programme as a whole, as well as increasing the likelihood of the client relapsing after leaving treatment (King and Canada 2004). The following discussion explores previous research in relation to predicting clients' non-attendance so that practitioners and services can proactively support their clients' engagement.

Milward et al. (2014), in a UK-based study, suggest non-attendance in substance misuse services is among the highest in the health services. They refer to Mitchell and Selmes' (2007) review paper suggesting 25-37% of all new patients' DNA every year in substance misuse services in the UK. Understanding the reasons for clients' non-attendance at outpatient appointments is a multi-layered problem for substance misuse service providers (Milward et al., 2014). They state that where reasons for non-attendance have been thoroughly described in the research literature, such reasons can be divided into two main areas; i). client-related issues, ii). service-related issues. Weisner et al. (2001) suggest higher drug usage, low motivation and being out of work as main client-related factors in relation to non-attendance. According to Milward et al. (2014), there are a number of patterns related to non-attendance, such as some clients will DNA occasionally, some frequently and some will completely dropout, and therefore more specific and client-centred motivational and therapeutic interventions would be required. This highlights a need to assess clients' attendance probability at early stages and develop a client-centred treatment plan to ensure enhanced levels of attendance and engagement. Having an understanding of client-related predictors in relation to attendance in a particular setting could provide prospective identification of clients at risk of non-attendance which could help treatment providers to reduce the percentage of non-attendance (Kruse et al., 2002).

Andersen (1995) further developed The Initial Behavioural Model (Anderen, 1968) and presented a model to predict factors associated with non-attendance at initial meetings within the mental health sector. Clients' predisposing factors, enabling factors, environmental factors and clients' need factors were suggested as the key predictors of non-attendance.

Accessibility is a complex concept and can be interpreted, studied and measured in different ways. Andersen (1995) suggests that potential access to a service can be simply defined as the presence of enabling resources such as external factors; i.e. family support or any such factors which can enable a client to access a service. Paige and Mansell (2013) summarise Andersen's model as predisposing factors including demographic characteristics such as age, gender and ethnicity, need factors including personal motivation to engage in treatment such as a desire to change and being psychological minded, and environment factors including availability of treatment, travelling and treatment options available.

Akter et al. (2014) interviewed health service staff (N=15; admin = 5, nurses = 5, doctors = 5), exploring their views on patients' non-attendance at health services in Australia. They highlighted the following main areas: implications of non-attendance (such as resource waste, poor service efficiency and reduced service accessibility for others); socio-economy status (linking low socioeconomic status and poor education, low self-esteem, lack of value of personal health, and chaotic lifestyle); age (younger/older); lack of health consciousness; lack of trust of authorities and confidentiality; client-specific factors (such as, accessibility of services and lack of consequences of non-attendance); and the patient-practitioner relationship.

In this section, I have discussed a range of complex issues related to clients' attendance specifically in relation to clients' retention in treatment. Next, I will discuss different ways of improving clients' attendance in light of studies included in this review.

2.10 Improving attendance

Barriers to attendance have a negative impact on clients' confidence in their ability to complete their treatment programme. Abraham and Michie (2008) show how addressing the barriers that affect the client's likelihood of return to treatment can increase self-efficacy and subsequently create more confidence in behaviour change and improve clients' attendance.

Motivation Interviewing (MI) is an integrated approach based on a person-centred model and behavioural theories. It is defined as "…a collaborative conversation style for strengthening a person's own motivation and commitment to change" (Miller and Rollnick,

2013: 12). The key tenets of MI are identification, exploration and working with ambivalence (Miller and Rollnick, 2013).

Using motivational interviewing (Miller and Rollnick, 2013) based interventions during the initial assessment meeting significantly enhances the chances of clients' attendance at the next session (Carroll et al., 2001). The clients' autonomy is one of the core principles of the British Association for Counselling and Psychotherapy's (BACP, 2018) ethical framework. It is important that clients seek support, and agree to the treatment plan without any undue external pressure. Mullins et al (2004) reported that no significant difference in attendance was noted when motivational interviewing interventions were offered to 'sent to treatment' groups such as pregnant women sent by child welfare services in the USA. This shows that the success of motivational interviewing interventions is dependent on clients' willingness to engage in treatment. This willingness can be described as an informed consent to a 'psychological contract' or as Clarkson (2003) refers, a 'working alliance'.

Change of practitioner and practitioner style are also considered contributing factors impacting clients' attendance at substance misuse services (Carroll et al., 2010). Pulford et al. (2010) undertook a review of controlled trials regarding treatment dropouts. They suggested that a change of staff either due to a staff member leaving, or due to interactions with various staff in different roles, impacts clients' engagement and attendance (Pulford et al., 2010). They reported that clients met with different staff members at different treatment stages, such as initial phone contact, face-to-face assessment and treatment sessions delivered by different members (Pulford et al., 2010). Clients were more likely to not attend the next meeting after experiencing a change of the worker (Babbar et al., 2018).

Clients' lack of planning, memory issues, chaotic lifestyles and being impulsive are some of the common issues with alcohol addiction (Sparr et al., 1993; Moeller et al., 2001; Gudjonsson et al., 2004; Patkar et al., 2004;). Using effective prompting interventions to remind clients near the time of their appointments could enhance attendance rate. Text message appointment reminders improve clients' attendance at alcohol outpatient clinics (Agyapong, 2013; Gullo et al., 2018). A meta-analysis of 18 studies by Guy et al. (2012) demonstrated 50% increase in attendance when patients were sent text messages about

their upcoming appointment regardless of the type of health service or what time the message was sent.

Clients who miss their appointments are particularly vulnerable to further harm as they receive no support (Garfield, 1994). This is even more concerning for those with addiction issues as accessing no treatment or support is likely the sign of continuation of alcohol or drug use leading to potentially more damage to person.

Sheeran et al. (2007), in a UK-based action research project, designed and implemented a novel idea – an 'implementation intention intervention' - in order to engage potential psychotherapy clients prior to their first meeting. They attempted to address negative feelings associated with the psychotherapy such as shame and stigma. This included randomly assigning 476 individuals to two groups – implementation intention (n=236) vs control conditions (n=240).

Sheeran et al. (2007) designed a specific appointment letter which included an 'implementation intention intervention'. "The implementation intention intervention comprised the following paragraph:

> 'People can sometimes feel concerned about attending their appointment. To help you to manage these concerns, please read the statement below 3 times and repeat it silently to yourself one more time:
>
> *As soon as I feel concerned about attending my appointment, I will ignore that feeling and tell myself this is perfectly understandable!*
>
> Now please tick the box below if you have read the statement 3 times and said it to yourself once (please be honest, do not tick the box until you have read and repeated the statement)' (Sheeran et al., 2007: 858).

Sheeran et al. (2007) reported that the implementation intention group members were more likely to attend compared to the control group members (75% vs 63%). Similar interventions could be utilised in the addiction field.

It could be argued that a 'pre-treatment' engagement phase may be similarly effective in working with clients with alcohol problems. Service providers could design and

implement a client-focused pre-treatment protocols that focuses on establishing trust in the treatment. This may include specific leaflets, social media messages or contact with other professionals such as GPs – specifically addressing clients' negative feelings about attending at addiction services. Perhaps just sending a referral letter is not sufficient in the addiction field. Rather, referrers must act proactively and support clients with any concerns and worries.

The previous studies have demonstrated that effective social support systems for clients were crucial in addressing their addictive behaviours. Much of the literature has focused attention towards the support offered outside of the consultation and therapy services (Dobkin et al., 2002; Orford et al., 2009). The previous research has shown that having a low social support outside of therapy services has been associated with higher levels of anxiety and distress, leading to significantly higher rates of DNAs over a six-month period. On the other hand, effective social support is associated with retention within the treatment programme, measured over a six-month time period (Dobkin et al., 2002).

Orford et al. (2009) looked more closely at the attributes of behaviour change that facilitate whether the client continues treatment or not. Involving significant others in a client's treatment signified a change in behaviour and retention in the treatment programme (Orford et al., 2009). Positive social support could therefore be seen as a significant factor in changing the non-attendance rates in alcohol treatment programmes, with a higher social support having a direct impact on the level of retention and completion of the treatment programme (Dobkin et al., 2002). Copello et al. (2002, 2006) developed, used, and evaluated Social Behaviour and Network Therapy (SBNT) as a comparative treatment approach, during the UK Alcohol Treatment Trial (UKATT) – a national multi-centre RCT of alcohol treatment in the UK. 'The overall aim of the treatment [SBNT] is to mobilise and/or develop positive social network support for a change in drinking behaviour' (Copello et al., 2002: 351). SBNT is based on three phases of treatment delivered in eight sessions over a period of 12 weeks. Phase 1 (session 1) focuses on identification of the client's network; phase 2 (session 2 - 7) involves building, engaging and mobilising the supportive social network; and phase 3 (session 8) focuses on consolidation of the therapeutic work undertaken during the phase 1 and phase 2 (Copello et al., 2002).

In this section I have highlighted strategies for improving clients' engagement and attendance at their appointments. These included developing social support networks for clients, use of pre-treatment interventions supporting initial treatment engagement, using appointment reminders, and use of motivational interviewing interventions. Except the use of supportive social networks, all other treatment engagement suggestions were based on non-alcohol research studies. The effectiveness of these interventions in relation to alcohol clients has not been studied yet. It would be useful to undertake specific research projects to study the effectiveness of above mentioned strategies regarding alcohol clients.

2.11 Chapter summary

The previous research findings can be broadly divided into four interrelated groups; i) client demographics, ii) client characteristics, iii) clinical factors, and iv) service delivery factors. Certain client demographics associated with higher non-attendance rates include; being male, unmarried, younger clients, ethnic minorities, financial issues, less educated and having no children. Client characteristics and clinical factors include polysubstance use, comorbidity - mental health issues, lack of support from family, motivational ambivalence to address their drinking, risk taking behaviour, additional complex needs, competing priorities, social isolation, being a smoker, and forgetfulness. Service delivery factors include a range of treatment provision barriers such as; longer waiting times, administrative delays, location of the service, conflict of staff, treatment environment (low in support and high in control), lack of: choice of appointment time, therapist, information interventions, attendance reminders and case management approach, weak client-practitioner working alliance, newly trained practitioners, lack of engaging activities, staff availability, lack of treatment continuity, and lack of client autonomy. Although previous research has established some understanding of client and service-related factors impacting clients' attendance at drug and alcohol addiction services, more research work is needed specifically focusing on alcohol treatment services within UK settings. It is clear that most of the previous research has focused on the DNA rates in drug support services globally. Only a small handful of studies have focused their attention on the alcohol services and the DNAs within their treatment programmes.

There is a paucity of research exploring clients' reasons for non-attendance at alcohol treatment services. Most previous research work has focused on clients dropping out or terminating their treatment. Non-attendance at treatment has been broadly examined in substance abuse and drug treatment service provision. However, only limited information can be found on the reasons for non-attendance in clients with alcohol abuse issues. Most of the non-attendance research on substance misuse is focused on 'drop out/withdrawal from treatment' rather than 'missing or not attending sessions' but not necessarily dropping out from the treatment. There has been no attention given to experiences of front line staff regarding their clients' non-attendance. In addition, most previous studies were based on quantitative research designs and therefore lack an exploration of clients' subjective experiences about their reasons for non-attendance as well as what can be done to improve their attendance.

In addition, there is a crucial omission in the existing literature in relation to explaining what really happens between clients booking a session and not attending. The explanation that certain client-related and service-related factors negatively impact clients' attendance seems insufficient because the same clients would attend their appointments at times in spite of the presence of the same client or service-related factors. In this mixed methods study I have endeavoured to address these gaps in research and explore the reasons for clients' non-attendance at a community-based alcohol agency. I have also included both clients and practitioners' perspectives about clients' non-attendance and their suggestions about improving clients' attendance.

In order to understand addiction, it is important to explore different lenses which can be used to explain how addiction works as well as to determine corresponding treatment strategies. In the next chapter, I will discuss different theories of addiction.

Chapter 3 Theories of Addiction

This chapter will focus on different theoretical approaches to explore, explain and understand addiction. It is not feasible to include an exhaustive list of theories in this dissertation and therefore a limited number will be included broadly covering different philosophical positions. I have included four theoretical concepts in this chapter; the disease model, PRIME theory, gestalt therapy theory, and attachment theory. I chose these theories because they covered a diverse range of epistemological and ontological positions. It is important to review a diverse range of theoretical explanations of addiction in order to appraise the relevant treatment protocols. This research study is focused on exploring clients' non-attendance at their treatment sessions. Non-attendance cannot be understood as an independent variable and it has to be explored in the context of different lenses of theoretical paradigms. Addiction is a complex, multi-layered and relational problem which needs a multifaceted theory to understand and treat addiction using a relational and field-focused treatment approach.

There are a number of theories of addiction which present different systems of ideas to explain addiction. In essence, a theory is a claim to understand human behaviour based on systematic observations of certain patterns of human behaviours and predict future behavioural responses (Farley and Flota, 2018). Interest in addiction dates back hundreds of years with references in Bible and Quran and many other historic texts. West and Brown (2013) present a comprehensive classification of theories of addiction based on common factors among different theoretical lenses. They divide these theories into two main categories: individual focused theories and population or group level theories.

The individual focused theories include; 'automatic processing theories, reflective choice theories, goal-focused theories, biological theories and integrative theories' (West and Brown, 2013: 153). The group level theories include; social network, economical, communication or marketing and organisational system theories (West and Brown, 2013). To explore in detail these above mentioned theoretical concepts is beyond the remit of this dissertation. The next section will explore four different theoretical lenses; the disease model, PRIME theory, gestalt theory and attachment theory. These theories were included

because they represented four different theoretical underpinnings which seek to explain and understand human addictive behaviour (West and Brown, 2013). As mentioned above, in order to explore clients' reasons for non-attendance at an alcohol addiction agency, it is important to understand different conceptual frameworks that explain addiction from different theoretical basis.

Using West and Brown's (2013) classification of addiction theories; the disease model would fit under biological theories; gestalt would fit both integrative theories (individual focused theories) and group level theories; attachment theory would fit under goal-focused and integrative theories and finally PRIME theory would cover different aspects of a diverse range of individual focused theories.

3.1 The Disease Model

The concept of the disease model, as Levine (1978) suggested, has origins from over 200 years ago and gained much popularity in 1930s and 1940s in the United States of America (Jellinek, 2010). White (2000) considers the 18th and 19th century writings of Anthony Benezet, Benjamin Rush, Samuel Woodward and William Sweetser as the building blocks of the disease model of addiction, primarily alcohol addiction. Benezet (1774 as cited in White, 2000) described alcohol as a 'bewitching poison'. Rush (1784 as cited in White, 2000) referred to drunkenness as an 'odious disease' and 'disease of the will', and Beecher (1825 as cited in White, 2000) declared 'alcoholism' as 'addicted to the sin'. Heather and Robertson (1997) offer three types of alcoholism based on the idea of addiction as a disease; i) A – a pre-existing problem, ii) B – a mental illness, and iii) C – an acquired alcohol dependency.

Jellinek (2010) presents a model of alcoholism based on its severity and claims the psychological dependency stages should not be considered as an 'illness per se' (p.37). Jellinek (2010) categorises alcoholism in four ways: Alpha alcoholism (purely psychological, used to relieve physical or emotional pain); Beta alcoholism (heavy drinking resulting in physical health problems); Gamma alcoholism (physical dependency, serious health and social consequences); Delta alcoholism (Gamma plus inability to abstain) and Epsilon alcoholism (binge or periodic drinking) (Jellinek, 2010).

The key tenets of this model are loss of control due to physiological responses; genetic predisposition, brain disease, involuntariness, and the only possible solution to alcohol addiction is complete abstinence (Leshner, 1997; Hall et al., 2015; Wiens, 2015).

Neuroscience has gained significant attention in the last two decades in the human development and behaviour change fields (NIAAA, n.d.). The brain disease model of addiction (BDMA) extends the definition of disease model as a 'chronic relapsing brain disease' (Hall et al., 2017). BDMA (Leshner, 1997) suggests that long-term use of a substance (alcohol or drugs) leads to enduring brain neuro-pathways impacting a person's decision-making process in relation to substance use. Some of the perceived benefits of the BDMA are enhanced focus on the effectiveness of medications, a medical view instead of moral view and therefore a reduction in 'self-blame' and 'stigmatisation' in relation to substance abuse. On the contrary, some of the disadvantages of this model are an impression of permanence and a suggestion that changes in brain functions leads to the 'hopelessness' in relation to personal will power and desire to change or overcome addiction (Hall et at., 2017).

Erickson and White (2009) claim that the dysregulations of neurotransmitter systems are of the main reasons for alcohol dependence. Gatley et al. (2005), on the basis of their study using advanced brain imagining techniques; single photon emission computed tomography (SPECT) and positron emission tomography (PET), suggest that the chronic use of substances lead to brain changes, impacting cognitive and memory functions. Erickson and White (2009) claim longer term alcohol use leads to structural changes to brain and reversal of certain functions during the abstinence phase. Sullivan, Rosenbloom, Lim and Pfefferbaum (2000) highlight the improvement of brain structure functions such as memory, attention, gait, balance and visuospatial functions once a person stops drinking.

The brain disease model has also helped to reduce the stigma attached with drinking/addiction. Hall et al. (2017) and Erickson and White (2009) have suggested that stigma and pressure on individuals to stop drinking themselves has been eased by a widespread understanding of addiction as a brain disease, supported by public information movements which have used the metaphor of a 'hijacked brain'. This has aided an understanding of why some people find it impossible to 'stop' drinking. Erickson and White

(2009) share their concern in relation to the stigma attached to addiction which questions "why some people cannot just say no" (p.342) to alcohol. They suggest promoting two main educational messages in the public domain a. that long-term recovery is possible, and b. that addiction-related neurobiological changes are largely reversible. It should be noted that this theory failed to acknowledge a range of human experiences in explaining addictive behaviours such as social influences, learned behaviours, emotional responses, environmental stressors, and interpersonal experiences.

3.2 PRIME theory

West and Brown (2013: 192) present a 'synthetic theory of motivation (PRIME theory)', which is a motivation-based addiction theory. The dynamic interplay (COM-B Model as presented below in Figure 3.1) of capability, opportunity and motivation systems, both conscious and unconscious, is the key tenet of this theory (West & Brown, 2013). See below COM-B model illustration;

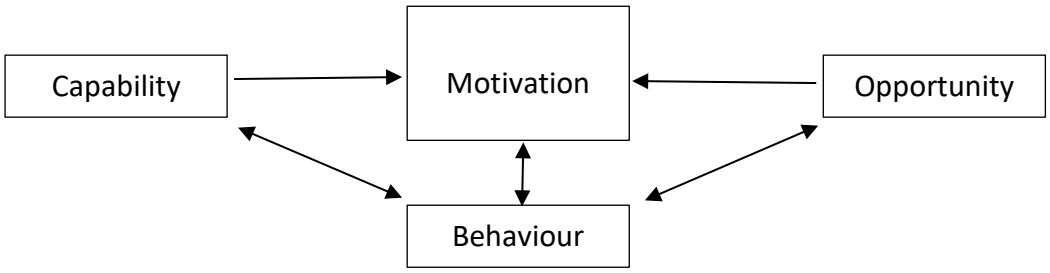


Figure 3.1: COM-B model; Source: West and Brown (2013)

According to the COM-B model (West and Brown, 2014), for any addictive behaviour to take place, the following conditions must be met; i) capability to perform a behaviour; ii) a person must have an opportunity to engage; and iii) a person must be motivated to engage in a particular behaviour. Prime theory (West and Brown, 2013) presents five interacting subsystems in the human motivation system; plans, responses, impulses, motives and evaluation. "Plans are self-conscious intentions; responses involve starting, stopping or modifying actions; impulses and inhibitions are the final common pathway to

behaviour; motives are feelings of want or need and evaluations are beliefs about what is good or bad" (West and Brown, 2013: 195).

West and Brown (2013) believe that the human motivational system is comprised of a complex interplay of different cognitive and emotional forces. The strength of this model is to present a detailed map of a person's motivational responses, including both pre and post processes linked with any substance intake behaviour. As this theory is fundamentally an explanation of how our motivational system works, it offers a rather simplistic view of the decision-making process, such as one would drink alcohol if one's motivation to drink is more than one's motivation to not drink. According to West and Brown (2013), identity (such as, a drinker or in recovery) has a figural role in relation to making any meaningful behavioural changes. They believe that identity, as an intrapersonal mental representation of self drives our behavioural directions (West and Brown, 2013).

West and Brown (2013) propose five laws of motivation; i) we respond to our influential motives; ii) our moral judgements (good or bad) impact our plans; iii) we need mental energy to act on our plans, and self-control (e.g. resisting temptation to drink) consumes reserves of our mental energy; iv. our self-identities are a powerful source of motivation; and v. our motives linked with impulses, inhibitions and our behaviour is managed by the strongest momentary impulses.

West and Brown (2013) mainly view the human motivational system as an intrapersonal phenomenon with some recognition of external environmental factors that influence one's behaviour. Miller and Rollnick (2013) relied on the similar template to conceptualise human behaviour, that is, motivation is an individualistic phenomenon. Miller and Rollnick (2013) presented a set of behvaiour changing treatment interventions – Motivational Interviewing, is widely used in the addiction treatment field (for more detailed discussion see Chapter 9). The next theory explores non-dualistic, that is, person and environment as an inseparable entity, approach to addiction.

3.3 Gestalt Therapy Theory

Gestalt therapy theory presents a holistic, existential and phenomenological approach where a person is seen as inseparable from his/her environment (Perls et al.,

1951). Parlett (1991, 1997) claims that gestalt therapy theory is in essence a gestalt field theory. Gestalt field theory (Parlett, 2005) proposes that a person and his environment influence each other, and so understands motivations, needs, urges, drives, inhibitions (all those processes which are actively linked with addiction) as a person's responses to person/environment interactions (Parlett, 2005). Fundamentally, Gestalt theory has an optimistic stance that human beings strive towards self-development and internally regulated balance (Perls, et al., 1951). A person creatively adjusts his contact with his environment or others in order to best deal with the demands of a situation. Addiction can be seen as a creative adjustment (Jacobs, 2017; Joyce and Sills, 2018) in order to find and sustain a manageable way to deal with challenging experiences and to survive difficult circumstances (Clemmens, 2005). It could be argued from the lens of gestalt therapy theory that getting drunk is a form of defense mechanisms a person can do in dealing with their internal and/or external challenges. On this basis, I would suggest that any meaningful recovery would involve substituting drinking with more suitable and healthy support systems

The cycle of experience (Figure 3.2) used in gestalt therapy theory is a helpful model to conceptualise the process of responding to human needs/urges (Joyce and Sills, 2018).

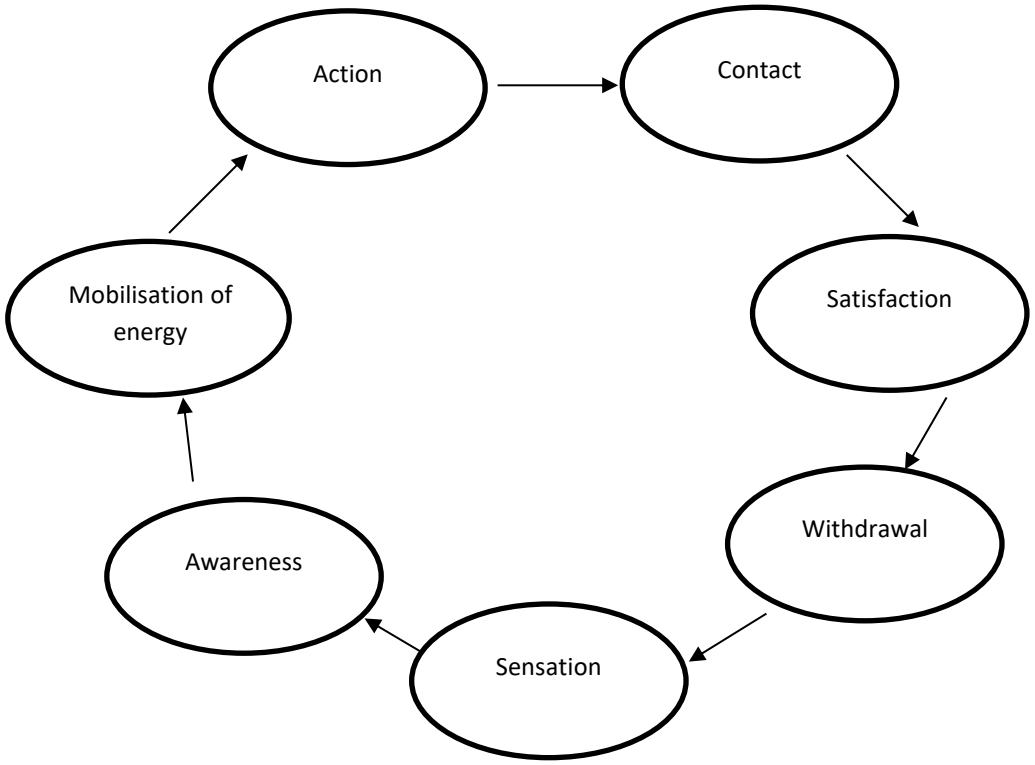


Figure 3.2: Cycle of experience; Source: Joyce and Sills (2018)

Using a cycle of experience (Joyce and Sills, 2018) lens, addiction can be described for different individuals as being stuck at different stages on this cycle such as 'awareness', 'satisfaction' and 'withdrawal'. Being stuck at 'awareness' would mean to 'mis-interpret' their sensations (e.g. social anxiety related sensation) as a need to drink. At 'satisfaction', a person would feel not satisfied even after drinking e.g. a glass of wine. At 'withdrawal' stage, a person would feel it is almost impossible to 'withdraw' from an activity – drinking. Being stuck leads to an experience of 'unfinished business' as the progression through the cycle is interrupted. One of the key tenets of the gestalt therapy theory is using 'paradoxical theory of change' (Beisser, 1970). "Change occurs, according to the paradoxical theory of change, when one becomes what he is, not when he tries to become what he is not" (Beisser, 1970: 77).

In brief, Gestalt approach to dealing with addiction focuses on the function of drinking in one's life and works with the resistance to change instead of working against the resistance to change. Motivational Interviewing (Miller and Rollnick, 2013) uses the gestalt perspective of working with one's motivation to maintain any change.

3.4 Attachment theory

Attachment theory (Bowlby, 1988) is fundamentally a human development theory and focuses on the initial bond between a child and care giver. Depending on those early bonding experiences a person will develop particular attachment styles such as secure or insecure attachments. The significance of early positive attachment experiences is further supported by medical research using modern scientific developments such as detailed brain scanning (Cassidy and Shaver, 2016). Scatliffe et al., (2019), in a cross-disciplinary systematic review comprised 17 studies, reported raised oxytocin levels in synchronously attached infant – carer bonds. Oxytocin is also known as the 'hormone of attachment' (Scatliffe et al., 2019: 445). Furthermore, research (Cassidy and Shaver, 2016) shows high activity in the left nucleus of the amygdala in secure attachment and high activity in the right nucleus in insecure attachment. It, therefore, can be argued that the concept of attachment patterns can be empirically demonstrated.

Addiction, applying an attachment theory lens, is using a substance as a substitute for a secure base. For many people the experience of addiction is similar to bonding with a

carer/parent where the desired substance helps to regulate emotions, provides rewards, offers a sense of safety and warmth, enhances self-esteem (even for a short period of time) and promotes creativity, play and freedom of expression. Thorboerg and Lyvers (2010) speculate whether addiction is an attachment disorder which may explain the notion of an 'addictive personality' – so it is not a substance that is a problem, it is a person with a problem – an attachment issue.

Attachment theory offers a platform to understand underlying emotional issues where drinking excessively is merely a symptom of much deeper issues (Cihan et al., 2014). Gill (2017: xiii) asks two questions; 'Is addiction a search for a secure base?' and 'does addiction provide the soothing and safety which are the features of an internalised secure base and from which the person can then emerge and engage in exploration?'. Golder et al. (2005) suggest that people with insecure attachment styles were more likely to develop addiction issues compared to one with secure attachment styles.

A history of insecure attachment impacts upon the individual's capacity to self-regulate (Khantzian, 2018). The notion of separation anxiety explains why an individual would find it really difficult to tolerate any separation from their choice of substance – to struggle to stop drinking. Similarly, a self-medication model of addiction suggests that a substance is used to alleviate emotional distress or pain and as an affect regulator (Khantzian, 2018).

Tronnier (2015), on the basis of Khantzian's (2012) article, argues that there is a limited life to the initial relief experienced from the use of a substance. Later attempts to achieve the similar relief leads to difficulties which then feeds back to internal dysregulation. Tronnier (2015) attempts to integrate 'Regulation theory' and 'self-medication hypothesis'. Regulation theory is fundamentally an expansion of Bowlby's (1988) ideas focusing on the early life interactions between an infant and caregiver. Schore (2000, 2003) suggests that in the early mutual communications, 'the infant and caregiver mutually convey and co-regulate positive and negative forms of psychobiological arousal towards the aim of homeostasis' (Schore, 2003 as cited in Tronnier, 2015). Therefore, early attachment experiences impact a person's self-regulatory processes and capacity to deal with addictive substances.

Khantzian (2012: 275) proposes four areas relating to a self-medication hypothesis,

> an inability to recognise and regulate feelings; an inability to establish and maintain a coherent, comfortable sense of self and self-esteem; an inability to establish and maintain adequate, comforting, and comfortable relationships; an inability to establish and maintain adequate control/regulation of behavior, especially self-care.

Many researchers and commentators such as Caspers et al. (2006), Fowler (2013), Thorberg and Lyves (2010) and Flores (2004) highlight a relationship between attachment history and one's support seeking attitudes and treatment attendance, engagement and retention. Therefore, it can be concluded that attachment styles are strong indicators of overall treatment outcomes. It is important to also consider the attachment styles of the addiction practitioners as a practitioner with insecure attachment style could also struggle with proximity and separation. Personal development and personal therapies for counsellors and psychotherapy trainees is one of the crucial training requirements (BACP, 2018; UKCP 2019) whereas in my experience there is no such requirement for substance misuse workers in the UK. If we consider the therapeutic relationship as a crucial element in the success of treatment outcomes, then this issue of personal development of addiction practitioners needs careful thinking.

3.5 Chapter summary

I have discussed four different theories of addiction in this chapter; the disease model, PRIME theory, gestalt therapy theory and attachment theory. As mentioned above, addition is a complex, relational and multidimensional problem and only a multifaceted theory can justly explain the process of addiction. In addition, a relational and unified field-focused treatment approach is required to support clients with addiction issues.

Chapter 4 Methodology

In this chapter I present the methodology used for this research. I explore epistemological, theoretical, methodological issues, both quantitative and qualitative strands and ethical considerations. This chapter consists of five sections; an overview of my methodology, detail on the quantitative and qualitative strands of my research followed by ethical considerations, quality control processes and reflexivity.

The first section (methodology) presents the overall introduction to the methodology and offers a theoretical exploration related to methodological issues. The second and third sections (quantitative and qualitative strands) present details of each strand including my research aims and objectives, and my approach to sampling, data collection, and data analysis. The fourth section examines how the ethical issues were addressed in this research. The fifth section focuses on reflexive discussion on undertaking this research.

4.1 Methodology overview

In this section I present the overall research aim and objectives, research design, methodological issues and rationale to use a mixed methods approach.

4.1.1 Research aims

The main aims of this mixed methods research are to i) determine predictive factors for clients' non-attendance at a community alcohol treatment service and ii) to gain a deeper understanding of the reasons for clients' non-attendance at appointments, within a community-based alcohol service from the perspectives of clients and practitioners.

4.1.2 Research objectives

The key objectives of this research were to explore;

- The extent to which clients' socio-demographic and clinical factors predict their non-attendance at a community-based alcohol service
- The reasons for clients' non-attendance as reported by clients and practitioners
- How clients and practitioners experience non-attendance?

- Clients and practitioners' suggestions to improve clients' attendance.

4.1.3 Research Design

This study used a mixed methods approach incorporating both quantitative and qualitative lines of enquiry in order to gain an extensive understanding of non-attendance from the perspectives of clients and practitioners. The simplified plan of the research design is shown in Figure 4.1.

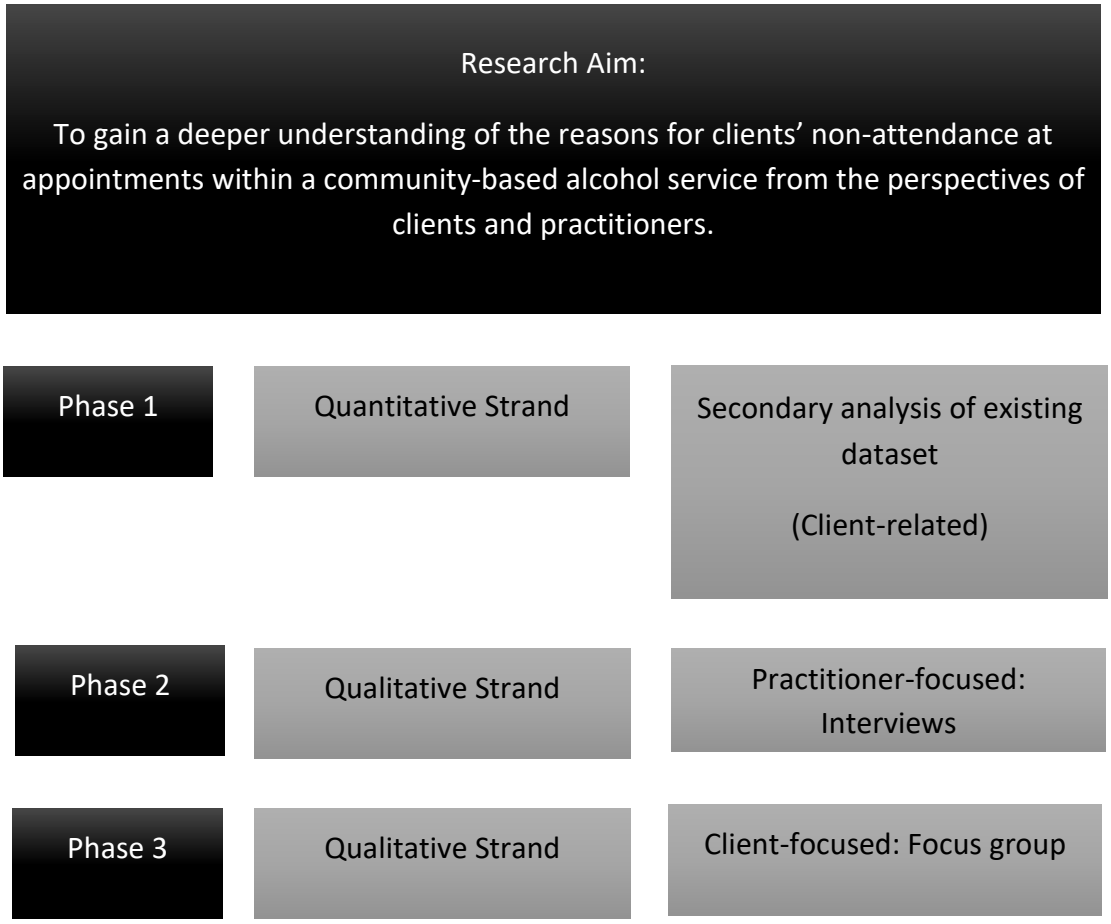


Figure 4.1: Overall research design

There is a dearth of research on the topic of reasons for clients' non-attendance at alcohol support appointments using a mixed methods approach and particularly examining practitioners' experiences in relation to their clients' non-attendance. As highlighted in the literature review chapters, most of the previous studies have used quantitative

methodology to explore factors associated with clients' non-attendance at addiction support services. Few research studies were identified that used a qualitative methodology and/or explored practitioners' experiences in relation to their clients' non-attendance. Using a mixed methods approach seemed the most appropriate methodology to explore clients and practitioners' experiences in relation to non-attendance at a community-based alcohol service. The quantitative strand focused on identifying predicting factors linked with clients' non-attendance, whereas the qualitative strand explored participants' (clients and practitioners) experiences and narratives. In this research, I endeavoured to offer a thorough investigation of the reasons for clients' non-attendance and possible solutions for improving clients' attendance at treatment sessions.

4.1.4 Literature review strategy for methodology

This section explores an additional literature search performed to support the methodological positioning of this research project. I used Creswell and Plano Clark's (2018) recommended literature search strategy in order to review existing mixed methods-based research projects using two 'search terms'; mixed method* and quantitative AND qualitative. The initial search was based on publications from 2000-2018, databases: PsychINFO, PsychARTICLES, Psychology and Behavioual Sciences Collection, ERIC, full text available, and in English language. The initial search produced 15,578 results using search term – mixed method*. With search term 'quantitative AND qualitative' 19,694 results were produced.

Reducing the time period from 2000 to 2010 (2010-2018) did not make any significant difference to the initial search results. The results slightly changed from 15,578 to 13,602 (using mixed method* search term). Reducing the timescale further to 2015 – 2018 produced 7,750 results. Finally, selecting only one journal 'journal of mixed methods research' reduced the search results to a manageable number 119. After an initial screening, 10 papers were selected for the full reading. This screening was based on the relevance of the research paper where the research methodology was clearly explained. In addition, commonly referenced books and papers, particularly work by the key mixed methods research authors was consulted such as; Creswell and Plano Clark (2018), Teddlie and Tashakkori (2009), Greene et al. (1989), Morse (1991), Mertens (2003), Bryman (2006),

Mayring (2007), Johnson and Onwuegbuzie (2004), and Johnson et al. (2007). This discussion also demonstrates a significant rise in mixed methods research projects in the recent years. The methodology focused literature review informed the design of this research mainly in two ways; to undertake multi-strand (quantitative and qualitative) parallel research and to use pragmatism as the epistemological base of this research.

4.1.5 Pragmatist paradigm

Research paradigms are crucial as they determine the direction and scope of any research study. For Guba and Lincoln (1994) the paradigm positioning holds a central position in any social science research. They say 'questions of methods are secondary to questions of paradigm, which we define as the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways' (Guba and Lincoln, 1994: 105). The following diagram (Figure 4.2) demonstrates how research paradigms are linked with research designs.

Figure 4.2: Research design and paradigm

A research paradigm explicates the assumptions and beliefs associated with our world-views (Guba and Lincoln, 2005; Teddie and Tashakkori, 2009; Merterns and Hesse-Biber, 2013). Research paradigms include the researcher's epistemological (what counts as knowledge?), ontological (what is the nature of reality?), axiological (what is the role of values?) and methodological (what is the process of research?) positions (Creswell, 2013).

As mentioned above, quantitative and qualitative methodologies belong to two different paradigms and therefore use different epistemological and methodological lenses (see Table 4.1). One of the challenges in this research was to deal with differences and perceived incompatibility between quantitative and qualitative approaches (Howe, 1988; Guba and Lincoln, 2005; Teddie and Tashakkori 2009; Creswell, 2013). Teddie and Tashakkori (2009) summarise some of the key differences as;

Table 4.1 Positivist vs Constructivism; Source: Adapted from Teddie and Taskakkori (2009: 88)

Dimension	Constructivism	Positivist
Methods	Qualitative	Quantitative
Logic	Inductive	Deductive
Epistemology	Subjective – co-constructed reality Researcher and participants are inseparable	Objective – dualism Researcher and participants are separate
Axiology	Value-fixed inquiry	Value-free inquiry
Ontology	Ontological relativism – multiple, constructed realities	Naïve realism (an objective, external reality that can be comprehended)
Causal linkage	Impossible to distinguish causes from effects	Real causes temporally precedent to or simultaneous with effects
Generalisation	Only idiographic statements emphasized	Nomothetic statements possible

Howe (1988) challenges the quantitative-qualitative debate and presents the 'compatibility thesis' (p.10). The key tenet of his proposal was based on the idea of a pragmatic paradigm - using combined quantitative and qualitative approaches (Howe, 1988). Creswell (2013) presents the basic ideas of pragmatism as follow;

- Pragmatism is not linked to any one philosophical system.
- Researchers are free to choose their research designs, methods and techniques as required conducting their study.
- Researchers are open to a range of data collection and analysis strategies.
- Historical, political, cultural, racial, social, personal and other contexts directly impact all research phenomena.
- Both dualistic and monolithic worldviews can be incorporated.

Pragmatists reject the view of complete separate entities of objective and subjective and deductive and inductive paradigm positions. They suggest that epistemological issues exist on a continuum instead of separate and contrasting polarities. Johnson and Onwuegbuzie (2004) describe pragmatism as,

> The project of pragmatism has been to find a middle ground between philosophical dogmatism and scepticism and to find a workable solution (sometimes including outright rejection) to many longstanding philosophical dualisms about which agreement has not been historically forthcoming. (Johnson and Onwuegbuzie, 2004:18).

Pragmatism rejects classic dualism and rather supports 'moderate and common sense versions of philosophical dualism' (Johnson and Onwuegbuzie, 2004: 18). Epistemologically, pragmatism believes that "knowledge is viewed as being both constructed and based on the reality of the world we experience and live in" (Johnson & Onwuegbuzie, 2004: 18). On the basis of the above discussion it can be argued that a mixed methods approach sits well within pragmatist paradigm. Table 4.2 presents the summary of the key features of pragmatism.

Table 4.2 Key features of pragmatism (Teddie and Taskakkori, 2009: 88)

Dimension	**Pragmatism**
Methods	Both quantitative and qualitative
Logic	Both inductive and deductive
Epistemology	Both object and subjective view points
Axiology	Values important in interpreting results
Ontology	Diverse viewpoints regarding social realities
Generalisation	Ideographic statements emphasised, both external validity and transferability issues important.

Pragmatists challenge the notion of epistemological rigidity and its importance in the research (Howe, 1988; Teddie and Taskakkori , 2009; Yardley and Bishop, 2007), and they present the idea of shared meaning and joint action. Greene et al. (1989) summarise different purposes for using a mixed methods approach: triangulation, complementarity, development, initiation and expansion. They explain each purpose as;

- 'triangulation – convergence, corroboration, correspondence of results from the different methods;
- complementarity – seeks elaboration, enhancement, illustration, clarification of the results from one method with the results from the other method;
- development – seeks to use the results from one method to help develop or inform the other method, where development is broadly construed to include sampling and implementation, as well as measurement decisions;
- Initiation – seeks the discovery of paradox and contradiction, new perspectives of frameworks, the recasting of questions or results from one method with questions or results from the other method;
- expansion – seeks to extend the breadth and range of inquiry by using different methods for different inquiry components' (Greene et al., 1989: 259).

The two above mentioned purposes or justifications, complementarity and expansion, are applicable to this research study. The quantitative study was designed to explain clients' non-attendance in the context of certain predicting factors such as clients' demographics, clinical factors, use of text messages and appointment times. The qualitative study was designed to explore clients and practitioners' views and experiences in relation to clients' non-attendance at a community alcohol service.

4.1.6 Methodological considerations

Methodology is, as Flick (2015) describes, a strategic approach to carrying out the research and discovering knowledge. It is a work plan or an overall strategy of how the research will be conducted. Research methodology informs and explains the study paradigm, data collection tools and data analysis method. It is a 'framework' within which the research is co-ordinated (Braun and Clarke, 2013). For Crotty (1998: 3), methodology is 'the strategy, plan of action, process of design lying behind the choice and use of particular

methods and linking the choice and use of methods to the desired outcomes'. A research methodology fundamentally addresses questions relating to data collection and data analysis such as; what, how, when, and why. Guba (1990: 18) describes methodology as 'how should the inquirer go about finding knowledge?' The following Figure 4.3 demonstrates the basic structure of levels of development of this research.

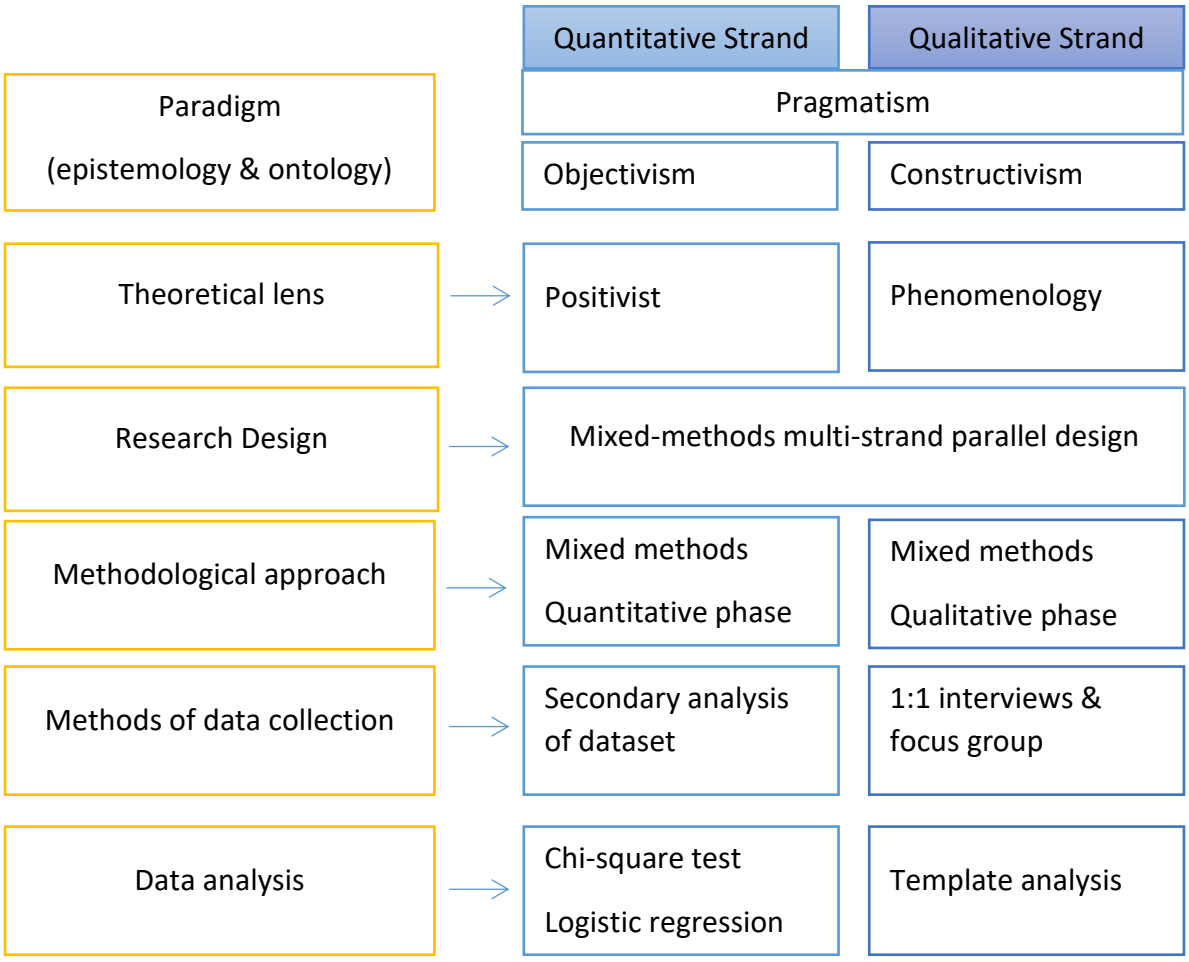


Figure 4.3: Theoretical foundations; Source: Adapted from Crotty (1998: 4)

This research project adopts a mixed methods approach holding a pragmatic epistemological position, that is, quantitative and qualitative approaches are compatible to be used in a single research project.

Where there are inherent differences between quantitative and qualitative forms of research in relation to their ontological, epistemological and methodological levels, they both share a common goal, that is, to investigate some form of truths. However, they claim different ontological (the nature of reality) and epistemological (the nature of knowledge or way of knowing) positions of worldview (Curtis and Drennan, 2013; Waring, 2017). Quantitative research usually holds a positivist viewpoint i.e. reality exists independent to us and it can be studied by different means such as experiments and observations. On the contrary, qualitative research involves a range of methods of data collection and data analysis and is primarily interested in understanding participants' experiences using different theoretical viewpoints such as constructionism, interpretative, critical inquiry, feminism and others (Crotty, 1998).

Objectivist epistemological views are based on the notion that objects exist with their objective meaningful existence independent of human awareness and consciousness (Crotty, 1998). On the contrary, constructionist epistemological positions claim 'meaning is not discovered but constructed' (Crotty, 1998: 42). Human consciousness and awareness of objects provides meaning to their existence; objects contain no independent meaningful truths. The very word of 'meaningful' requires a presence of someone to make a meaningful interpretation. Crotty explains the concept of constructionism; 'they (objects in the world) may be pregnant with potential meaning, but actual meaning emerges only when consciousness engages with them' (1998: 43) using Merleau-Ponty's assertion that 'the world was always already there' (Merleau-Ponty, 1962: vii). As mentioned above, 'meaning is not discovered but constructed', and it can be argued that constructionism offers both polarities – objective and subjective realities.

No one specific epistemological position can claim to have access to the entire truth or the only access to the truth. The positivist movement claims that real knowledge can only be established through testable experiments (Braun and Clarke, 2013). This approach is mainly based on Descartes' dualism – subject versus object (Rozemond, 2002). The focus of a positivist study is an object which is separate from the researcher. Much effort is utilised in order to avoid any 'subjective' contamination of the object by tying to maintain 'neutral' position as the researcher (Creswell and Plano Clark, 2018). They use structured, repeatable, measurable, quantifiable, deductive, and 'scientific' approaches to seeking 'knowledge of

reality'. The key task of a positivist researcher is to describe and/or explain an observed phenomenon. Constructivism or interpretative movements fundamentally believe in multiple truths and realities subject to the interpretations of the researcher (Creswell and Plano Clark, 2018). A researcher cannot achieve or maintain a complete neutral position as an investigator and therefore directly impacts the emergence of reality. The 'reality' is relational, subjective, contextual, and fluid (Braun and Clarke, 2013). The key task of a constructivist researcher is to experience, understand and interpret a given research phenomenon (Creswell and Plano Clark, 2018). The next section will present the mixed methods approach used in this research project.

4.1.7 Mixed methods approach

"A new star" and "the third research paradigm", are some of the labels associated with mixed methods research (Tashakkori and Teddlie, 2003; Johnson and Onwuebuzie, 2004). 'It [mixed methods approach] is an intuitive way of doing research' (Creswell and Plano Clark, 2018: 1).

There are a number of definitions of mixed methods approaches, however, the common description is based on collecting and analysing both quantitative and qualitative data in a rigorous manner (Creswell and Plano Clark, 2018). Johnson et al., (2007) presented their definition based on 19 published definitions of mixed methods approaches.

> Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purpose of breadth and depth of understanding and corroboration. (Johnson et al., 2007: 123)

Mixed methods approaches have gained significant popularity in the social, behavioural, nursing, psychology and related fields (Plano Clark and Creswell, 2008) and this is evident in the large number of mixed method research projects published in recent times. The rise in mixed methods approaches is a serious challenge to 'the incompatibility thesis', as put forward by Howe (1988), that claimed that 'mixing' of quantitative and qualitative approaches is incompatible (Plano Clark and Creswell, 2008; Teddie and Tashakkori, 2009).

4.1.8 Mixed methods multi-strand parallel design

Mixed methods research designs can be broadly divided into two categories; single strand designs, that is either qualitative or quantitative research designs, and multi-strand designs involving both qualitative and quantitative designs. Teddie and Tashakkori (2009) present five types of mixed methods multi-strand designs; parallel, sequential, conversation, multi-level, and fully integrated. Table 4.3 presents a summary of the key feature of different multi-strand designs (Teddie and Tashakkori, 2009).

Table 4.3 Summary of multi-strand mixed methods designs

Multi-strand designs	Key features
Parallel	• Mixing occurs in a parallel manner – simultaneously or with some time lapse.
Sequential	• Chronological mixing • Research questions and / or procedure of one strand emerge from the previous strand
Conversion	• Parallel design • Mixing occurs when one kind of data is transformed and analysed both quantitatively and qualitatively • Same research questions
Multi-level	• Parallel or sequential design • Mixing across multi-levels of analysis • Data analysed and integrated at different levels
Fully integrated	• Mixing occurs in an interactive manner at all stages • At each stage, one approach affects the formulation of the other

(Source: Teddie and Tashakkori, 2009: 151)

This research can be described as the mixed-methods multi-strand parallel design (Teddie and Taskakkori, 2009) that can be represented using Morse's (2010) notational illustration (see Figure 4.4) (adapted) as;

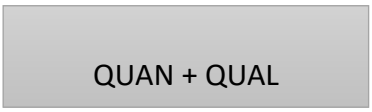


Figure 4.4: Mixed-methods multi-strand parallel design adapted from Morse's illustration

This research has two strands (quantitative and qualitative), each including 'all of the stages from conceptualisation through inference' (Teddie and Tashakkori, 2009: 145). Parallel mixed designs are described by Teddie and Taskakkori (2009: 151) as 'in these designs, mixing occurs in a parallel manner, either simultaneously or with some time lapse; planned and implemented QUAL and QUAN phases answer related aspects of the same questions'.

Morse (2010) does not offer a QUAN + QUAL option as he claims that one theoretical drive (either QUAN or QUAL) should be an overarching theory. He has therefore used capital letters to describe the main theoretical drive such as 'QUAN + qual - indicating a quantitatively driven research project followed by a qualitative project' (Morse, 2010: 340). This offers rather an assimilative approach such as 'results of the supplementary component will be integrated into the results of the core component' (Morse, 2010: 341). The current research does not really fit Morse's presented model. Teddie and Tashakkori (2009) do not present such restrictive view in their definition of parallel mixed designs. They describe it as '…two parallel and relatively independent strands: one with QUAL questions, data collection, and analysis technique and the other with QUAN questions, data collection, and analysis techniques. …. Inferences based on the results from each strand are integrated to form meta-inferences at the end of the study' (Teddie and Tashakkori, 2009: 152). A visual model of this mixed methods research is provided in Figure 4.5.

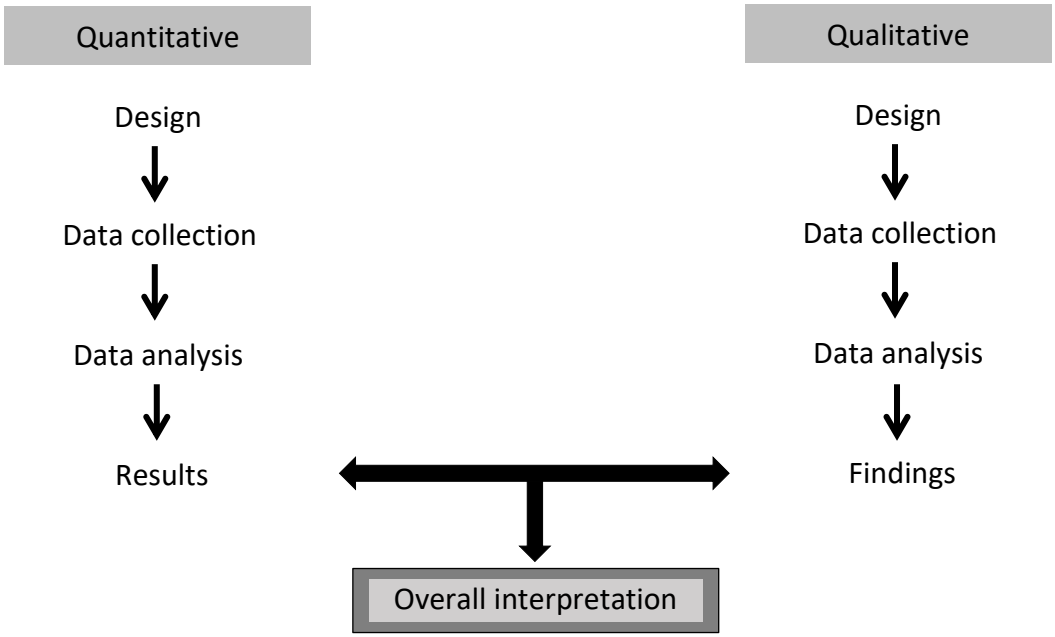


Figure 4.5: A visual model of a mixed methods research study. Source: Creswell (2003)

4.1.9 Quality control and triangulation

Denzin (1978: 291) defines triangulation as 'the combination of methodologies in the study of the same phenomenon'. Triangulation can be explained as a process to improve the credibility, reliability and trustworthiness of a research work. Different forms of triangulation included; theoretical, data, methodological and researcher (Patton, 2002; Guba and Lincoln, 2005). Triangulation is, as Teddie and Tashakorri (2009: 33) explain, 'the combination and comparison of multiple data sources, data collection and analysis procedures, research methods, and inferences that occur at the end of a study'.

This research study incorporated triangulation of data and between-method triangulation (Flick, 2004). There was triangulation of data because the qualitative strand included different types of data collection methods (individual interviews and focus group) from different sources (practitioners and clients). There was between-method triangulation because both qualitative and quantitative methods were included. According to Creswell and Plano Clark (2018), methodological triangulation and mixed methods designs are parallel concepts. For Flick (2004), there are three modes of triangulation, 'as a validation

strategy, as an approach to the generalization of discoveries, and as a route to additional knowledge' (p.183).

Teddile and Tashakkori (2009) summarise the advantages of a mixed methods research design; it concurrently explores confirmatory or predicting (quantitative) and exploratory (qualitative) variables; it offers stronger inferences, and it provides a greater variety of divergent perspectives. The quantitative strand explored the predicting factors for clients' non-attendance, whereas the qualitative strand explored both practitioners and clients' perspectives and their suggestions of ways to improve clients' attendance.

This study offered the convergence of findings from quantitative and qualitative strands, for example, data from the practitioners' interviews confirmed the results of quantitative strand such as ethnic minorities and younger clients were more likely to miss their sessions. This study also clarified a divergent perspective, that is, quantitative and qualitative strands offered diverse findings for example, the impact of text message reminders on clients' attendance (for more discussion see chapter 5). In brief, the quantitative strand demonstrated that text message reminders did not increase clients' attendance, however, the qualitative strand revealed that text messages reminders were important strategy in order to improve clients' attendance according to clients' perspectives. The following diagram (Figure 4.6) depicts the process of triangulation in this research study.

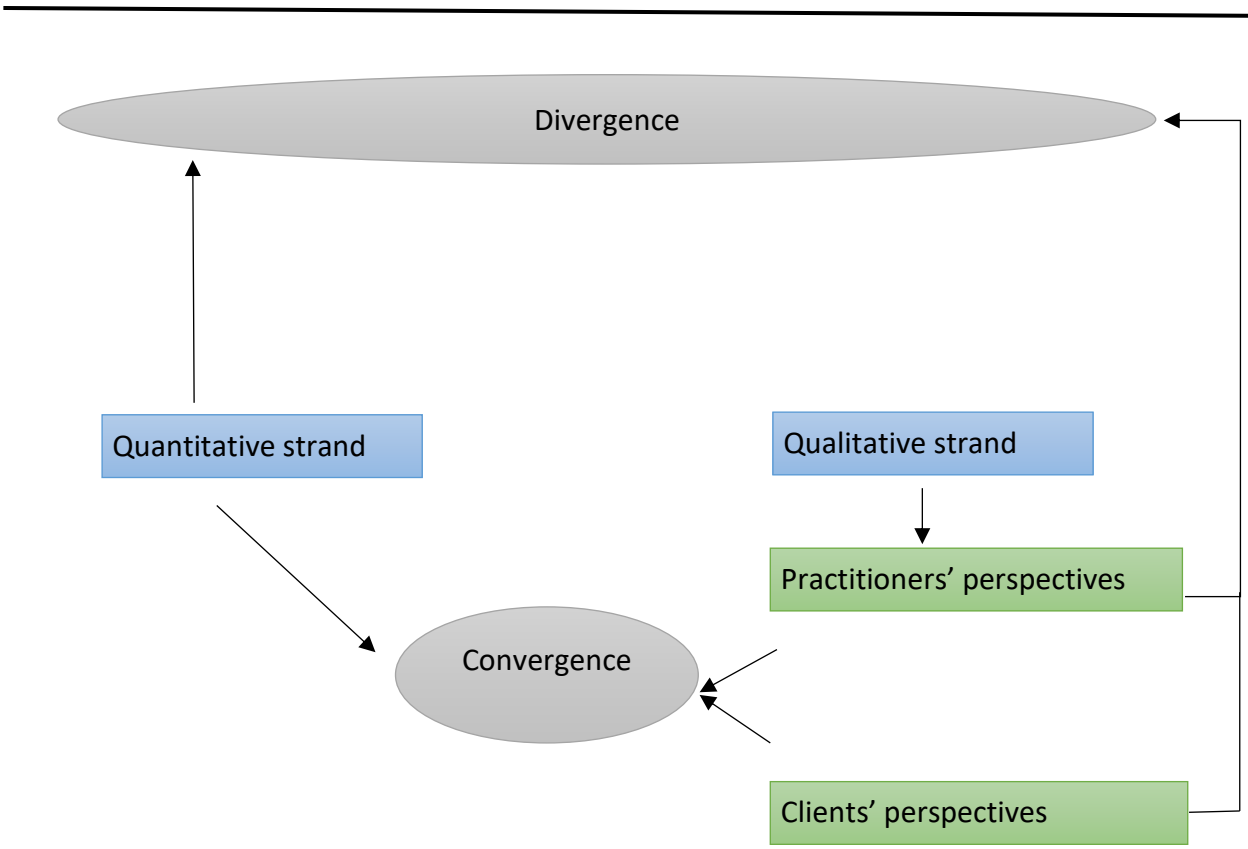


Figure 4.6: The triangulation process

In relation to qualitative research, Creswell and Plano Clark (2018) suggest the following three strategies to establish qualitative validity;

1. Member-checking – the researcher shares the summaries of the data analysis with the participants.
2. Triangulation of data – data collected from several different sources.
3. Disconfirming evidence – reporting disconfirming findings confirms the authenticity of the data analysis process mainly because it is inherent that people will present contrary views in relation to the same phenomenon.

Triangulation has two separate functions; first, using different data, methodological, and theoretical processes to study the same phenomenon. The second function is to ensure research validity, reliability, internal consistency, trustworthiness, and authenticity. According to Creswell and Plano Clark (2018) both quantitative and qualitative research approaches aim to achieve good data and results' validity; data validity and results reliability in quantitative research and trustworthiness and authenticity in qualitative research.

The researcher shared the step by step process of quantitative data collection and analysis including SPSS worksheets with the research supervisory team. In addition, in order to enhance the quality of qualitative data analysis, the initial coding and '*a priori*' template was shared with the supervisory team. The researcher completed the coding of three interview transcripts (practitioners' interviews) independently and then discussed all three transcripts and coding with the supervisory team.

4.2 Quantitative strand

In this section, I will present the research aim, research questions, data collection process, and data analysis related to the quantitative strand. The quantitative strand involved secondary analysis of existing data on clients' attendance at services from one community-based alcohol misuse service.

4.2.1 Aim and objectives (Quantitative strand)

The key aim of the quantitative strand was to explore factors predicting clients' non-attendance at appointments within a community-based alcohol service.

The main objectives of the quantitative strand were;

1. To determine the socio-demographics factors that might predict clients' attendance at a community-based alcohol service.
2. To explore the statistical relationship between clinical factors in relation to clients' rates of attendance.
3. To determine the impact of text message reminders and appointment times on client's attendance.

4.2.2 Research questions (Quantitative strand)

The research questions for the quantitative strand were;

- To what extent do the socio-demographic factors of clients such as age, gender, ethnic origin, employment status, accommodation needs, parental status, and number of children living with client predict non-attendance?
- To what extent do the clinical factors of clients such as risk levels, smoking status, pregnancy, dual diagnosis, and overall discharge reasons predict non-attendance?
- To what extent do the receipts of text messages (appointment reminders) predict non-attendance?
- To what extent do the session times predict non-attendance?

4.2.3 The existing dataset

The quantitative element of this study involved secondary analysis of anonymised client data from one community-based substance misuse service in the Midlands, United Kingdom (see Chapter 1, Section 1.7). The dataset included demographic information, clinical factors, attendance records, assessment information, and treatment outcome measures for all clients registering with the service between 2010 and 2013. This cohort was selected because the service introduced a service-wide database application that included shifting from paper-based record keeping to a computerised system in 2010. A convenience sampling strategy (Lavrakas, 2008) was used because I was an employee of this organisation at the start of this research project (subsequently moved to a different employment) and I was interested in using research findings based on existing data to good effect to feed back into the organisation. I endeavoured to understand clients' reasons for non-attendance and how their attendance could be improved.

4.2.4 Summary of the dataset

The secondary dataset used in this research can be summarised as follows.

- Data from 10 sites of a community-based service offering support service from different regions in the West Midlands, UK
- Appointments attendance history: 4 years (Jan 2010 – Dec 2013)

- Unique service users: 22,405
- Number of appointment sessions: 194,679
- Gender breakdown: Male 66%, Female 34%
- Age Range breakdown: 25-34 – 28%, 35-44 – 34%, 45-54 – 23%, Other – 15%
- Overall attendance breakdown: Session attended – 62%, Cancelled by client – 13%, Cancelled by service – 2%, DNA – 23%

The data comprised 194,679 treatment appointment attendance history of clients (n=22,405) of four years (Jan 2010 – Dec 2013). The dataset included 13 variables (age, gender, ethnic origin, employment status, accommodation needs, parental status, number of children living with client, risk levels (assessed on the basis of presenting risk), smoking status, pregnancy, dual diagnosis, overall discharge reason, history of sent text message reminders and sessions times were also available. The above-mentioned variables were included because the service collected this information as per their commissioning contracts. The agency's data collection requirements were guided by the UK's National Drug Treatment Monitoring System (NDTMS) – a national substance misuse treatment database populated for commissioning purposes, service design, regional comparisons, resource allocations and service provision and implementation in England. Due to data protection requirements an anonymous dataset was provided for this research in an Excel datasheet format. Dataset descriptions are provided in Table 4.4

Table 4.4 Data variables (quantitative strand)

Variables	Categories
Age	18-24 25-34 35-44 45-54 55-64 65-74 75+

Gender	Female Male
Ethnic origin	African/Caribbean Bangladeshi Pakistani Indian Chinese Indian Mixed/Multiple ethnic group White Other
Parental status	All the children reside with client Some children reside with client None of the children reside with client Children reside with other family Children in care Client pregnant No children Declined to answer
Event type (session type)	Individual session Arrest referral Assessment Care plan review Family session Healthcare review meeting
Risk levels	High risk Low risk Medium risk No risk Not risk assessed / risk assessment incomplete
Housing needs	Independent YP - unsettled accommodation Independent YP with No Fixed Abode NFA - urgent housing problem No housing problem YP living in care YP living with relative YP supported housing
Smoking	Never smoked Ex-smoker Current smoker

Pregnancy	Yes No
Dual diagnosis	Yes No
Discharge reasons	No contact Incomplete treatment Treatment completed Transferred
Pregnancy	Yes No
Dual diagnosis	Yes No
Employment status	Carer Homemaker Economically Inactive Receiving benefits Not receiving benefits NEET (not in education, employment, or training) Unknown Unpaid employment Employed Unemployed Retired

The service runs a number of projects which are mostly commissioned by the local authorities and their service contracts are set as per Public Health guidelines (PHE, 2018) adhering to the Drug Strategy 2010 (gov.uk, 2010). Their existing database was designed in 2009 and evolved over the years as per business requirements. The categories of each variable (see above Table 4.4) were set in line with their contractual requirements. All England-based drug and alcohol services (commissioned by local authorities) are required to submit their performance data to the NDTMS (National Drug Treatment Monitoring System) NDTMS is a national database and it collects a range of data across the country with regard to trends of drug and alcohol use and treatment activity data. It includes a range of information about people in treatment such as number of drug and alcohol users in

treatment, waiting times, discharge reasons, numbers of re-referrals/re-presentations, types of drugs used, poly substance usage, alcohol related hospital admission, BBV (blood borne virus) support, involvement of family members, and outcome of their treatment (NDTMS, n.d.). The main function of NDTMS was to monitor how effectively drug and alcohol treatment services are planned, commissioned and delivered by the local authorities (NDTMS, n.d.).

I familiarised myself with the nature of data collected, a range of reporting tools used, database software, data cleansing and data checking protocols and the range of information stored. As mentioned above the agency provided a commissioned service in the region and was contractually required to upload their data for a national database for output and outcome measurements, data recording and reporting was taken seriously by the agency. All sites were issued monthly data qualitative assurance reports to address any data omissions and errors. This aspect was particularly beneficial for this research project as the dataset was potentially in a good condition.

4.2.5 Secondary data analysis

This quantitative strand used secondary dataset analysis to address the above-mentioned research objectives. Secondary data analysis is, according to Smith et al. (2011), analysing existing data 'that was collected by someone for another primary purpose' (p.920). It was decided to use an existing dataset as it had two key advantages; it was nearly impossible to collect such a large new dataset for this research project and the existing data set provided the 'real' data of the real clients who decided to attend or not attend their sessions without being part of any research study. Time and cost efficiency are commonly reported benefits of secondary data analysis (Smith et al., 2011; Heaton, 2004).

Trinh (2018) highlights risks of using existing datasets such as modifying existing dataset to produce statistically significant trends and not recognising the limitations and biases of existing data. It is worth noting that the dataset for this research was taken from a service that was subject to rigorous performance accountability. It is possible that the data was subject to unconscious bias in order to appear to be a performing service.

In addition to the advantages of using existing data, there are many challenges associated with secondary data analysis. The main challenge is that the data is not collected for the purposes of the research project and may or may not be compatible to the research aims. In this research, I simultaneously explored the nature of the data that was potentially available and my proposed research aims.

4.2.5.1 Limitations of secondary data analysis

Langkamp et al. (2010) highlight two main limitations of missing data; i) negative impact on statistical power due to reduced sample size and ii) statistical analysis based on valid cases (removing cases with missing values) may be biased if the missing values were systematically different. In this study, both of these risks were minimal.

In this study, the key limitations of secondary data analysis included:

i. Missing data – Only 50% of the client data was deemed valid for the logistic regression (see chapter 5) due to missing data. It is possible that the results of the quantitative data analysis would have been different with the full valid dataset. However, it is important to note that the total number of valid data cases was still significantly large and did not compromise the basic assumptions of logistic regression.

ii. The data were collected for service delivery purposes and therefore did not include certain variables that I wanted to include in this study (e.g. religion, weekly alcohol unit consumption).

iii. Data integrity - The clients' data were collected by the service primarily to fulfil the service level agreement requirements, that is, to demonstrate the effectiveness of the service provision. The impact of a 'payment by results' contractual provision at some sites might have impacted the credibility of the data recording practices. There was inconsistent data collection, recording and quality control practices at different service sites that also contributed to the disadvantages of secondary data analysis. Some sites had dedicated data entry officers, for example, while others relied on alcohol practitioners for data input due to a lack of resources. The agency introduced new data collection

applications in 2009 which subsequently went through three different upgrades during 2010-2013, including additional data entry fields or categories, depending on national level changes to alcohol and drug treatment data reporting requirements. Some variables had too many categories such as 'discharge reasons', for example, 'treatment completed – alcohol free' and 'treatment completed – occasional user' thereby increasing the risk of inaccurate and/or inconsistent data recording.

iv. The agency only focused on variables that were required by the service commissioners and influenced funding. Therefore, they did not include variables like sexuality, religion, previous treatment history, and weekly alcohol unit consumption. They also did not include practitioners' data, which would have been useful to explore the impact of practitioner-related factors on clients' non-attendance.

v. Another limitation of secondary data analysis is that it is not possible to ascertain the meaning of 'not known'. It is possible that different practitioners may have recorded 'not known' in a number of situations such as a client refusing to answer or a practitioner forgetting to ask this question.

In brief, there were advantages and disadvantages of using secondary data analysis in this study (McKnight and McKnight, 2011). Overall, the benefits of using secondary data analysis outweighs the limitations. The advantages include; accessibility to a large dataset, real life data, and time and cost efficiency. The key limitations were; originally, the data were not collected for research purposes, the risk of inconsistent data recording practices and that missing data possibly had an impact on the results of this study.

4.2.6 Data analysis

The data (n= 22,405) were analysed using a hierarchical four-stage binary logistic regression model. The chi-square analysis was undertaken for descriptive purposes only. Logistic regression was appropriate to determine which client factors predict non-attendance, as the outcome variable is categorical with two levels (attended/non-attendance). SPSS version 21 was used for the statistical analysis.

One of the main challenges was to 'tidy up' the data in order to use SPSS software for the analysis. Data preparation involved the following process of removing 'additional' data which was not within the scope of this research projects such as;

- Where a drug was recorded as a primary substance instead of alcohol (agency offered some drug support service in one of their projects for a short period of time).
- Any data where a 'family member' was the main client (agency offered support service to family members in their own right in some of their projects).
- Where clients' ID was created as 'anonymous' on the system to record telephone support to unregistered clients. Anonymous clients' service delivery activity was a part of some of the projects' service contracts. No personal demographic information was recorded for these anonymous clients. Only a number was generated to record 'brief advice provided' as an activity.

4.2.7 Data transfer Excel to SPSS process

Before transferring the data from Excel to SPSS, a number of steps were taken to ensure that the dataset was prepared for statistical analysis. The following Table 4.5 shows the step by step process used before transferring data to SPSS.

Table 4.5 Steps by step data transfer process from Excel to SPSS

1. Used CONCATENATE formula to create 'unique id' for each client – using unique ID and 'episode' number. This is to identify each session independently.
2. CONCATENATE(SUBSTITUTE(A2,"AQ","14",1),B2) formula was used to remove '/' within a 'cell' – this is to ensure smooth transition for data from Excel to SPSS.
3. Session dates were changed from dates to session number, using the following formula IF(CONCATENATE(A2,B2)=CONCATENATE(A1,B1),F1+1,1)
4. =IFERROR(VLOOKUP(AK2,'XXX'!$A$4:$C$53, 3, FALSE), 'XXX!$C$54) was used to change the following 'text' based information into numerical in order to best fit in SPSS. Event type, Attendance, Team Name, SMS Messages, Accommodation, Employment, Dual Diagnosis, Ethnic Origin, Gender, Parental status, Number of children living with client, Risk levels, Smoking & Discharge reasons.

4.2.8 Rationale for using logistic regression

The aim of this analysis was to determine which factors were significantly associated with clients' non-attendance for treatment, including their socio-demographic, clinical history, SMS text message reminder, and event time variables. The data were first analysed using chi-square analysis for descriptive purposes, followed by hierarchical logistic regression to determine which factors can predict non-attendance.

The clinical data were analysed using a hierarchical four-stage binary logistic regression model. Logistic regression was appropriate to determine which client factors predicted non-attendance, as the outcome variable is categorical with two levels (attended/non-attendance), which were coded as 0=attended, and 1=non-attendance. In hierarchical regression, variables or sets of variables are entered in stages (or blocks), so I can assess what contribution each block of variables (e.g., sociodemographic factors, clinical history, SMS, event time) adds to predicting the outcome variable (non-attendance), after controlling for previous variables (Pallant, 2013). In addition, logistic regression accepts both continuous and categorical independent variables (Pallant, 2013; Field, 2017). Block 1 of the logistic model analysed the impact of socio-demographic factors on non-attendance; Block 2 assessed the impact of clinical history factors on non-attendance; Block 3 tested the impact of receiving an SMS message reminder on non-attendance; and Block 4 analysed the impact of event time on client non-attendance. Logistic regression is commonly used in health and clinical research to identify what factors predict a client having one outcome over another (in this case whether or not a client did not attend). For further details, see Chapter 5 (Results).

4.3 Qualitative strand

The qualitative strand raised two separate lines of enquiry; practitioners' viewpoints of clients' non-attendance and clients' perspectives. The qualitative strand served to triangulate the results of the quantitative strand (Greene et al., 1989). It also offered in-depth understanding of issues related to clients' non-attendance, practitioners' experiences, clients and practitioners' suggestions regarding how to improve clients' attendance and

engagement as well as comparative narrative of practitioners and clients' experiences. Morse (1998: 224) supports using different lenses in order to gain better understanding of a phenomenon and he states 'because different lenses or perspectives result from the use of different methods, often more than one method may be used within a project so that researcher can gain a more holistic view'. Qualitative research provides rich and detailed data and it involves exploration and interpretation of participants' personal and social lived experiences (Silverman, 2001; Smith, 2008; Coombes, et al., 2009). This section will present clients' perspectives, practitioners' perspectives and data analysis. I conducted practitioners' interviews first and then conducted the focus group with clients. Figure 4.7 shows qualitative strand research design;

I. Practitioners' perspectives
II. Clients' perspectives
III. Data analysis

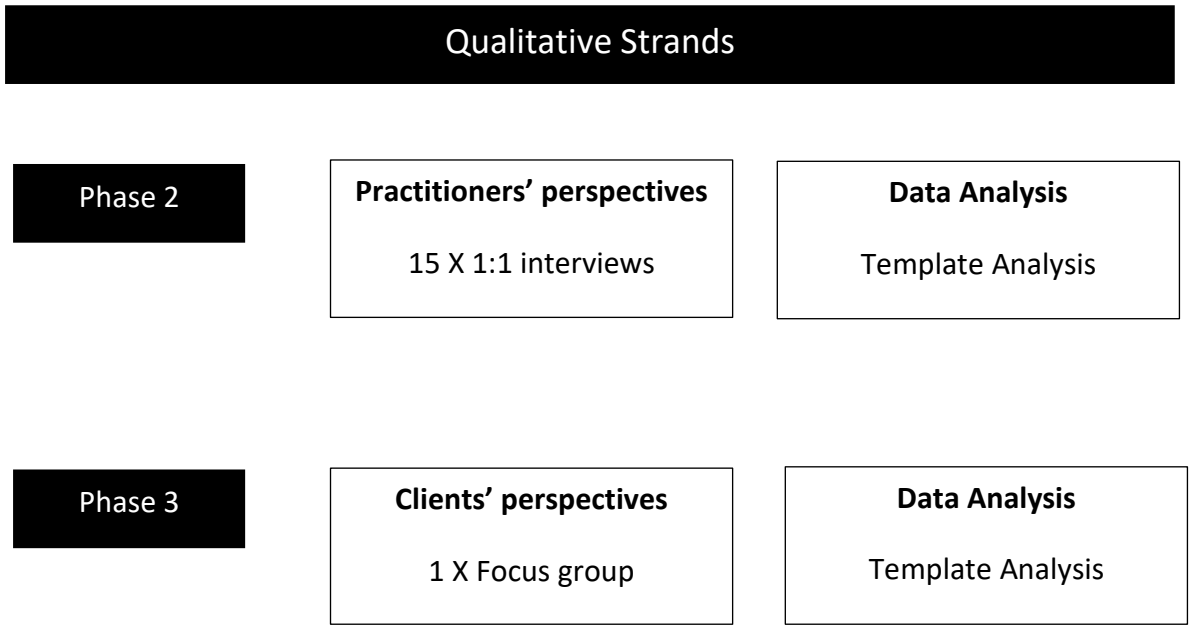


Figure 4.7: Qualitative strand research design (Phase 1 = quantitative strand)

4.3.1 Practitioners' perspectives

This section outlines the research questions, research aims and objectives for the qualitative strand (practitioners' perspectives), data collection and data analysis method.

4.3.1.1 Research aim and objectives (Practitioners' perspectives)

The aim of this qualitative strand was to explore practitioners' perspectives with regard to their clients' reasons of non-attendance at appointments with a community-based alcohol service and how their attendance can be improved.

The key objectives were;

1. To explore practitioners' views of the reasons for clients' non-attendance at appointments with a community-based alcohol service
2. To explore practitioners' experiences of their clients' non-attendance at appointments with a community-based alcohol service
3. To explore practitioners' suggestions with regard to improving clients' attendance.

4.3.1.2 Research questions (Qualitative strand – practitioners' perspectives)

The research questions for this qualitative strand (practitioners' perspectives) were;

- What are the main reasons for clients' non-attendance at appointments within a community-based alcohol service in practitioners' views?
- How do practitioners experience their clients' non-attendance – exploring their (practitioners) thoughts, feelings, interpretations and behaviours about their clients' non-attendance?
- What do practitioners think will improve their clients' attendance?'

4.3.1.3 Sampling

Sampling strategy is a crucial process in any research project (Teddlie and Yu, 2007). As the key focus of a qualitative study is to describe, understand and interpret experiential narratives, the sampling strategy is required to collect data that is intense, detailed,

descriptive, and saturated (Polkinghorne, 2005). Robinson (2014) presents a four-point approach to qualitative research sampling; sample universe (inclusion and exclusion criteria, target population), sample size (epistemological vs practical), sampling strategy (purposive), and sample sourcing (site; participants from the target population). Purposeful sampling (Coyne, 1997; Teddlie & Tashakkori, 2009; Creswell and Plano Clark, 2011; Creswell, 2013) is considered the main sampling strategy in a qualitative study. Morse (1991: 127) defines appropriateness of the selected participants as requiring "…a "good" informant (i.e. one who is articulate, reflective, and willing to share with the interviewer)". Having a clear sampling strategy is also crucial as the selected sample will have a significant impact on the researcher's capacity to address the research questions. Polkinghorne (2005: 139) states that 'the unit of analysis in qualitative research is experience, not individuals or groups'. The scope of qualitative research is to understand 'experiences' of selected participants instead of its distribution in a population.

Heterogeneous purposive sampling strategy was used in this qualitative strand. Saunders (2012: 42) defines heterogeneous purposive sampling as '… (choosing) participants with sufficiently diverse characteristics to provide the maximum variation possible in the data collected'.

Staff in a range of roles at the participating alcohol support agency were selected for this study to ensure a diverse range of experiences. Saunders (2012: 42) proposes a strategy 'aking a diagonal slice' in order to include staff members in a range of roles within the agency such as support workers, practitioners, senior practitioners, managers, and senior managers with a varied range of experiences in the addiction field. Patton (2002) considers the effectiveness of this approach as it increases the chances of including diverse range of experiences in relation to a specific phenomenon.

4.3.1.4 Participants

The following inclusion criteria were applied in this qualitative strand;

Inclusion criteria:

- Staff working in different roles employed by the agency.
- Support workers/ alcohol practitioners / senior practitioners / managers

- 18/+ years old
- Experience of working with service users with alcohol issues

4.3.1.5 Sites

Two sites (out of 10 sites) were used for this study for the following reasons;

- Travelling distance for the researcher – both sites were within 10 miles travelling distance.
- One of the sites is the head office of the agency and most of the practitioners and managers were based there.
- Some of the largest service delivery contracts were delivered from these two sites
- Both sites have a diverse range of staff members from support workers to senior management as well as number of years of working experience in the addiction field from 2 years to 20 years.

4.3.1.6 Recruitment procedure

In order to recruit participants, I reached out to the Chief Executive Officer of the Agency to obtain written permission via email regarding supporting data collection and access to participants. I arranged a telephone meeting with the Area Manager responsible for the two sites that I was looking to engage. I requested the area manager to forward email to both teams including aims of the study, inclusion criteria and participant information sheet (Appendix D). Subsequently, I then contacted the service managers of two sites in Birmingham and Solihull, UK, requesting their support. Site managers were happy to encourage their staff members to participate in this study and they emailed me the list of interested participants with their contact details. Initial contact with participants was via email to arrange the details such as interview date, time and venue. This initial contact provided me an opportunity to outline the aims and objectives of the research project, respond to any queries regarding the interview process and research aims, and to find a mutually convenient date, time, and venue for the interview. Once the time, date and

venue were confirmed via emails, I contacted the agency's site administrator to book a room.

I conducted nine interviews at site 1 and six interviews at site 2. The length of interviews ranged from 36 minutes and 42 seconds to 1 hour and 17 minutes, the mean length was 46 minutes.

4.3.1.7 Data collection tool

I used semi-structured interviews to explore practitioners' experiences. According to Braun and Clarke (2013) semi-structured interviews are well-matched data collection tools where research questions are concerned with exploring participants' experiences. The key features of the semi-structured interviews with practitioners included; I had a list of questions in line with the research aims and objectives, I had the opportunity to prompt the participants to elicit more information and seek further clarification, the participants had a greater flexibility to respond freely and include new information including raising unexpected issues (Braun and Clarke, 2013). According to Braun and Clarke (2013: 78) in semi-structures interviews 'the researcher has a list of questions but there is scope for the participants to raise issues that the researcher has not anticipated'. The key aim of these interviews was to offer an opportunity for open dialogue between the researcher and participants, allowing me to gain in-depth descriptive data on the participants' experiences (Coombes et al., 2009). These interviews supported the participants to reflect on their feelings, experiences, beliefs, thoughts, and suggestions in relation to client's non-attendance. Coombes et al. (2009: 197) describes semi-structured interviews as '... a broad set of questions that they[interviewer] want to ask, but encourages the interviewee to develop and expand upon issues that they deem important and lets the questioning flow naturally dependent on how the interviewee responds'.

In order to explore participants' experiences of clients' non-attendance and their suggestions to improve clients' attendance rate, I developed an interview schedule (Appendix F – Practitioners' Interview Guide). The interview guide included questions about practitioners' experiences of specific patterns related to clients' non-attendance, commonly reported reasons for non-attendance by their clients, the impact of practitioner-client relationship on clients' attendance, and how to improve clients' attendance. I also collected

participants' demographic information in order to assess the diversity and limitation of the sample.

Previous research literature and results of the quantitative strand informed the key areas of the interview guide. The quantitative strand and previous research (Booth & Bennett, 2004; Jackson et al., 2006) highlighted that certain client groups were more likely to not attend, such as, younger clients, ethnic minority clients, clinically high risk clients and unemployed clients. I included a question to explore my participants' views on these results (for example, Q4. Current evidence suggests that certain client groups are more like to not attend such as; younger clients (18-24); unemployed clients; high risk clients – as per agency risk assessment; ethnic minority clients. 4a. Do these findings fit with your experience? 4b. Why do you think DNA might be greater for those groups?). I included questions about practitioner-client relationship and its impact on clients' engagement (Meier et al., 2005; Palmer et al., 2009). In addition, I added questions regarding participants' suggestions about improving clients' attendance (Wierzbicki and Pekarik, 1993; Coulson et al., 2009)

4.3.1.8 Pilot Study

Before commencing the main data collection phase, I undertook a pilot study. Two people participated and helped me to improve the research design by;

- pre-testing of questions in the semi-structured interview schedule
- assessing the suitability and efficacy of the sampling strategy, that is, purposive sampling for practitioners' interviews technique
- assessing the feasibility (practical arrangements) of the research study
- determining what resources (travelling, cost etc.) were needed for a planned study
- assessing the proposed data analysis approach, that is, would template analysis be a suitable approach with regard to analysing the qualitative date.

The outcomes of the pilot study informed additional changes to the semi-structured interview guide (Appendix F – Practitioners' Interview Guide). The key changes included; more concise phrasing, for example, what do you do when your clients don't turn up? which was changed from, in case of your client's non-attendance, what procedures and protocols do you follow to address your client's absence? more open ended questions, for example, what kind of factors impact on a practitioner-client relationship); and added additional

questions, for example, in your views, what are the implications of non-attendance on clients' recovery?

4.3.1.9 Data analysis

Template analysis (TA) was used to analyse both individual interviews (practitioners) and the focus group (clients) in this research. Template analysis can be described as a form of thematic analysis of qualitative data (King, 2012). The basic essence of template analysis is to construct a 'template' of the key themes identified by the researcher after the initial data familiarisation process. The initial step is to create a list of 'a priori' codes that capture certain expected themes based on the research questions and interview guide. Creating *a priori* themes prior to the full analysis of the data makes template analysis different from Braun and Clark's thematic analysis. In thematic analysis (Braun and Clark, 2013: 202-03) the sequence of data analysis is based on different stages such as; familiarisation, generating initial codes, searching for themes, reviewing themes, defining and name themes, and producing the report. In template analysis, we start from a priori themes. An initial template is created by adjusting (if required) a priori codes after analysing some data (such as first 3 transcripts out of total 15).

The initial template is applied to the full data and adjusted (if required) during the process of thorough analysis of each transcript. This process of reviewing and editing the template continues until the completion of full data analysis and the final version of the template is created. The researcher's interpretation of the dataset is based on this final version of the template.

Template analysis offers a balanced approach between top down and bottom up qualitative data analysis (King, 2012). *A priori* themes are mainly based on the research aims and in line with interview questions – top down approach. It is also a bottom up approach because the initial template could be amended as the new and different information emerges during the coding process by changing exiting themes or adding new themes. This balanced top-down and bottom-up approach offers a congruent and phenomenological (Spinelli, 2005) position for the researcher to address their unconscious biases and preconceived positioning.

In template analysis 'coding' is usually hierarchical i.e. main theme (e.g. Impact of Brexit on addiction research), sub-themes (e.g. lack of collaboration; reduced funding; increase in UK based researchers). A researcher endeavours to achieve a balanced position between 'high degree of structure in the process of analysing textual data with the flexibility to adapt it to the needs of a particular study' (King, 2012: 426).

King (2012) presents seven phases of template analysis; i) define *a priori* themes, ii) transcription and familiarisation of data, iii) Initial coding (matching data with *a priori* themes), iv) producing initial template (based on sub-set of data), v) developing the template (based on the full data set), vi) interpretation, and vii) quality and reflexivity checks.

Template analysis (TA) offers certain flexibility in terms of its application from different epistemological positions. Brooks and King (2012) suggest that it can be used when exploring underlying reasons of human phenomena from 'constructivist' position that human experiences can be interpreted in a number of ways.

A priori themes are not essential requirements of TA however they are commonly used. This is because certain thematic assumptions are made at the start of any research project that which specific issues to be focused during data collection stage. The research aims and questions are the focus of the research and *a priori* themes are mainly based on those aims and questions. The level of flexibility available using TA is a particular strength of this approach as it suggests holding any preconceived ideas '*a priori* themes' lightly and the template based on initial *a priori* themes should be adjusted in light of emergence of any relevant and significant themes during analysis. I developed an *a priori* list of themes after analysing and coding three interview scripts with regard to practitioners' individual interviews. The initial *a priori* themes were;

- Reasons for Non-attendance
- Client demographic factors
- Clinical factors
- Therapeutic engagement/working alliance
- Impact on recovery
- What and how can be improved

- Limited funding

The template was then adjusted several times during thematic coding of the rest of the dataset before finally developing the final version – Version 4 (for more information see Chapters 5 and 6). I made relevant changes to the initial template in order to include new emerging themes. I changed 'descriptive' names of the main themes to 'thematic' titles in order to capture the essence of the participants' experiences and perceptions.

4.3.2 Clients' perspectives

This section outlines the research questions, research aims and objectives for the data collection from the clients, and data analysis.

4.3.2.1 Research aim and objectives (Clients' perspectives)

The aim of this strand was to explore clients' perspective with regard to their reasons (as a client) for non-attendance at appointments and how they perceived their attendance could be improved.

The key objectives were;

1. To explore reasons for clients' non-attendance of appointments with a community-based alcohol service.
2. To explore clients' experiences in relation to their and other clients' non-attendance at appointments with a community-based alcohol service
3. To explore clients' suggestions with regard to improving their attendance

4.3.2.2 Research questions (Qualitative strand – clients' perspectives)

The main aim of this study was to answer the following questions:

- What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service?

- How do clients make sense of their 'non-attendance' – exploring their thoughts, feelings, interpretations and behaviours?
- What do the clients think might improve their attendance?

4.3.2.3 Participants inclusion criteria

The following inclusion criteria were used for the recruitment of focus group;

Inclusion criteria:

- Service users of a particular site - one of the two sites (used for practitioners' study) selected to conduct the focus group study
- Anyone 18 or over
- has experienced or is experiencing alcohol misuse issues at some point in your life
- has experience of some kind of treatment for alcohol misuse - either one-to-one or group counselling/work
- able to attend the group meeting without being intoxicated.

4.3.2.4 Recruitment challenges

The original plan was to undertake 1:1 semi structured interviews with the service users /clients. The recruitment of the participants (clients) became a challenge and after nearly seven months' effort I only managed to recruit three service users. On the interview day, two participants did not turn up and one participant turned up heavily intoxicated and it was neither feasible nor ethically appropriate to go ahead with the planned interview. The main challenge was inherent to the focus of this study – trying to interview clients with a history and an ongoing pattern of non-attendance. Shame and embarrassment, of not attending their sessions, were also possible reasons for some clients to avoid taking part. It is also important to highlight that the agency was going through a major tendering process at that time and staff members were predominately occupied with their thoughts around job security and business sustainability. As practitioners were the gatekeepers for

recruitment, their preoccupation might have also impacted the recruitment of their clients in this study.

Practitioners consistently explored their clients' reasons for non-attendance and it was deemed possible that practitioners will be able to report their clients' reported stories with regard to their non-attendance. During the process of practitioners' interviews, it was suggested by some practitioners that a focus group (MacDougall and Fudge, 2001) would be a more practical strategy to recruit service users. The focus group discussion was well attended by the service users. It is possible to assume that a group meeting appeared as less shame-inducing compared to 1:1 interviews mainly because it was possible to talk about non-attendance as a generic issue instead of personal issue. Difficulty in attending the interviews does also demonstrate credibility in that these clients were not self-selecting: being the clients who did not DNA.

4.3.2.5 Participant recruitment

At the start of the third phase (clients' focus group) the CEO of the agency informed me that one of the two sites (used for practitioners' interviews) will not be available for clients' focus group due to changes in the service delivery agreement. In consultation with my research supervisory team and the agency's senior leadership it was agreed to only use one site for clients' focus group. The same site was also used for practitioners' interviews. In order to recruit participants (clients) for the focus group, I emailed to the site manager in Solihull, UK, requesting their support. I arranged a follow up telephone meeting with the service area manager for an initial discussion. I requested the service manager to forward research participation invitation email to her team members including aims of the study, inclusion criteria and participant information sheet (Appendix D). I also attended their team meeting and met with a number of practitioners and support workers to explain the function of the focus group and offer any further clarifications required regarding inclusion criteria. It was agreed that practitioners and support workers will liaise with their clients regarding participating in this study. The service manager liaised with her team members and collected names of clients who had agreed to participate as per inclusion criteria (see 4.3.2.3).

A group of clients agreed to participate and suggested to arrange the focus group either before or after one of their support groups to avoid further travel costs. I accepted the clients' request and arranged the focus group on the same day of their alcohol support group to ensure that clients feel valued and empowered. The focus group comprised eight clients who met the inclusion criteria. The norm is to recruit between four and eight participants for focus groups (Wilkinson, 2008). The focus group lasted for 1 hour and 56 minutes.

4.3.2.6 Focus group

As mentioned above (see 4.3.2.4), due to recruitment challenges I switched from 1:1 interviews to focus group in consultation with my supervisory team. Focus groups are a useful method to access data which are not easily accessible through individual interviews (Morgan, 1997). Group members' interactions in a focus group provide insight into a diverse range of experiences about a given phenomenon including similarities and differences of opinions. One of the advantages of focus groups is that such information (differences or similarities) is readily available compared to mining out comparative experiences after meticulous processes of post hoc analysis of separate interview transcripts (Morgan, 1997). Murphy et al. (1992) claim that the groups can produce more information than individual meetings even with the same participants. The key advantages of focus groups are 'being inexpensive, data rich, flexible, stimulating to respondents, recall aiding and cumulative and elaborative' (Fontana and Frey, 1994: 365).

Braun and Clarke (2013) have summed up the advantages and disadvantages of using focus groups. The advantages include, flexibility, high ecology validity, reduce power imbalance between researcher and participants, and access to microcosm of social interactions of participants otherwise not available in 1:1 interviews (Braun and Clarke, 2013). The key disadvantages include, lack of in-depth follow-up of individual experiences, can be difficult to manage, logistic challenges, transcription of focus group data can be very time-consuming for researchers, and managing group level deflections (Braun and Clarke, 2013). Foster-Turner (2009) concurs with Braun and Clarke (2013) and presents the following advantages of focus groups;

- Focus groups provide participants with the opportunity to develop and refine their ideas through discussion and interaction with like others.
- The method is valuable in engaging disadvantaged and marginalized groups and those who feel they have nothing to say.
- Focus groups tend to be quicker and cheaper to undertake than many other types of research. (Foster-Turner, 2009: 215)

In preparation for conducting the focus group, I carefully considered Kandola's (2012) recommendations; clarification of the project and how focus groups can help, sampling strategy – inclusion and exclusion criteria, clear communication to the potential participant to ensure participation, to ensure everyone contributes in the group, group facilitation skills, and developing an environment of trust and safety.

I introduced the discussion about the ground rules at the start of the group in order to support the environment of trust. I invited the group members to contribute to developing the list of ground rules to promote a sense of equality and openness in the group. As a group we agreed to the following ground rules, see below Table 4.6.

Table 4.6 Focus group ground rules

- The discussion should take approximately one hour to one and half an hour.
- Mobile phones switched off (or silent)
- Try to talk to each other, instead of answering the moderator
- No right or wrong answers, feel welcome to share your experiences and viewpoints
- It's OK to agree or disagree with each other, however please do so in a respectful manner.
- One person at a time – avoid talking over each other
- I (moderator) may interrupt the group discussion if these ground-rules are not being followed.
- I may intervene in order to keep the discussion on track and to support a lively and productive discussion.
- Confidentiality – no personal identifiable information will be shared outside the group (see 4.4.5 for more information regarding confidentiality)

One of the key differences between individual research interviews and focus groups is that the researcher acts as a group moderator or facilitator instead of an interviewer. The key tasks of a focus group moderator are to encourage participants to engage fully in the group discussion and interact with each other (Wilkinson, 2008). Wilkinson (2008: 189) further states that 'focus groups are a good choice of method when the purpose of the research is to elicit people's own understandings, opinions or views'. I was an experienced and qualified group psychotherapist that supported the process of group facilitation and moderation.

I followed a five-stage model of moderating a focus group as proposed by Finch et al. (2014). The following diagram (Figure 4.8) presents the stages of a focus group;

Figure 4.8: Stages of a focus group; Source: Finch et al. (2014: 218)

I started the focus group by introducing himself, the key aims of the research, reiterated issues regarding informed consent, anonymity, and confidentiality, and stating the ground rules as provided above Figure 4.8. The participants were asked to read and sign the consent form (Appendix D). In addition, participants were invited to comment on the ground rules. All participants agreed to sign the consent form and the above-mentioned ground rules. The participants were invited to introduce themselves in turn by stating their preferred names. I commented on the formation of the group such as, we have a mixed

group in terms of range age and gender. Group participants also named that there were no ethnic minority participants in the group. After the group participants' introductions, I introduced the opening topic – see focus group guide (Appendix I). I ensured that all participants were encouraged to contribute and supported interactions between participants in order to gain sufficient and rich data. At different stages, I introduced different topics in line with the research objectives. Flick (2009) refers this process as a facilitator's task of topical steering. Towards the end, the researcher shared the key summary points with the group and invited any corrections or brief additional comments. Finally, the researcher thanked all group participants for taking part in the discussion and invited group members to stay for any informal discussion including debriefing after the recording equipment had been switched off.

The researcher followed the essential tasks suggested by Finch et al. (2014: 223) as a group moderator; 'keeping the discussion relevant and focused, choosing when to allow more free-ranging discussion with minimal intervention, knowing when to use silence as a means of promoting further reflection and debate, deciding when to move on to another topic, having been making a mental note of issues that have already arisen which will need to be covered later in more depth'. The researcher used a range of simple, prompting and encouraging interventions such as, 'say more', 'can you please elaborate…', and 'can you give an example….'. The researcher encouraged other participants to join the discussion such as, 'I am wondering how others feel about what X shared' and 'I am wondering if others have similar or different experience in relation to this'. Before moving onto another topic, the researcher offered brief thematic summary and offered a link to the next topic such as, 'we talked about issues in relation to not getting text message reminders in a consistent manner, and I am wondering what could be done to improve the situation'.

4.4 Ethical considerations

Ethics is crucial to a good research project (Boulton, 2009). The Economics and Social Research Council, UK (2015) propose six key principles for research ethics; i) quality, ii) integrity and transparency, iii) informed consent with regard to aims, methods and purpose of the research including any possible and potential risks involved, iv) anonymity and

confidentiality, v) voluntary involvement of participants, avoidance of harms to all included parties - participants and researchers, and vi) any conflict of interest explicitly reported.

Webster et al. (2014: 78) summarise key ethical research principles;

- 'That research should be worthwhile and should not make unreasonable demands on participants
- That participation in research should be based on informed consent
- That participation should be voluntary and free from coercion or pressure
- That adverse consequences of participation should not be avoided, and risks of harm known
- That confidentiality and anonymity should be respected'

Ethical research is a dynamic constant process (Smith et al., 2009) that requires constant, consistent and conscious attitude towards ethical values and decision-making process (Farrimond, 2012). To ensure adherence to above mentioned ethical research principles, I endeavoured to follow an ethical research mindfulness attitude throughout this research project. The following discussion will explore how I addressed the issues of informed consent, confidentiality, anonymity, consent withdrawal process, and commitment to non-maleficence.

Prior to data collection, the researcher gained ethical approval (Appendix B) from the Ethics Committee of University of Bedfordshire (subsequently the researcher transferred to Manchester Metropolitan University, UK). Furthermore, an additional ethics approval was also obtained from the Institute of Applied Social Research Ethics Committee – University of Bedfordshire (IASREC). As the research plan changed, such as, using a focus group for clients and individual interviews with practitioners, further ethical approval was secured from ethics committee at Manchester Metropolitan University in 2017 and 2018 (Appendix C).

I carefully explored a range of ethical considerations in the context of the following domains; data sharing, participants' informed consent, withdrawal of consent, confidentiality and its limitation that is, disclosures of harm or illegal activity, dissemination of the outcomes of the research to participants, storage of data, safety of the researcher and participants, and additional support information for participants.

I obtained written consents from all participants (practitioners and clients) before commencing individual interviews and the focus group. I ensured that all participants were fully aware that they were under no obligation to take part in this research, aware of their rights to withdraw, and informed about the main purpose of this study.

Ethics approval from the institutions and the agency can be found in appendices B, C and E. Other associated documents are also included in appendices;

- Official ethics approval letter from IASRCE (University of Bedfordshire) (Appendix B)
- Additional information about ethics applications and approval (Appendix C)
- Agency's permission letter to use their dataset (Appendix E)
- Participant information sheets and consent forms (Appendix D).

4.4.1 Data protection (quantitative strand)

As mentioned above, the existing dataset was used from a Midlands based community alcohol service for the quantitative strand. The agency's data officer provided anonymous client data in an Excel document and CSV (comma separated values) format. The data file was emailed to me using 'secure email' i.e. nhs.net. This is a secure email system which meets the strict information governance and data protection standards of NHS. As I only had access to anonymous data, the data sharing did not require any specific consent from the service users.

> 'The current Data Protection Directive, dating from 1995, says that the principles of data protection shall not apply to data rendered anonymous in such a way that the data subject is no longer identifiable.' (Information Commissioner's Office, 2012).

In line with Information Commissioner's Office (2012) guidelines the agency did not include any data relating to less than five individuals to avoid any unintentional identification of a service user. For example, if there were only three Chinese clients registered at one particular site then they were removed from the dataset in order to protect their identity.

4.4.2 Participant information sheets (qualitative strands)

It was imperative that participants could make an informed choice as whether to take part in the research. Therefore, the information about the nature of the research and what was expected in relation to their participation was conveyed to potential participants in advance. This information was presented in a clear and understandable manner in the form of a Participant Information Sheet (Appendix D). I developed two Information and consent forms - one for alcohol practitioners and the other for clients (Appendix D).

The information sheets provided the following information:

- the basic aims of the research
- method and type of data that will be collected
- time commitment expected
- information and contact details of the researcher and supervisors
- confidentiality and anonymity conditions
- participants' criteria
- participants' right to withdraw from the research at any point (up to the point of publication) without any negative impact and in these circumstances any data collected will be destroyed within 2 days
- data storage information
- participants' right to refuse to answer any questions
- timescale for destroying data.

4.4.3 Informed consent (qualitative strands)

Written consent to participate in this study was obtained from each participant (practitioners and clients). The concept of informed consent means that participants were provided sufficient information about the research aims and objectives, the researcher's expectations of their involvement, and any other relevant information to enable them to make an informed decision without any pressure (Webster et., 2014). In the service of absolute clarity, and in line with customary practice to obtain signed informed consent from participants (Bryman, 2012), I developed a written participant information and informed consent sheet (Appendix D) documents. The Informed consent is, as described by Boulton

(2009: 37), 'the way participants are included in a study: that is, on the basis of a decision by the participant, which has been made voluntarily and with an understanding of all the information likely to be relevant to their decision'.

At the end of the Participant Information Sheet, I provided an explicit statement asking the participants to acknowledge that they have read the content of the information sheet, or have had it read to them, and agree to take part in the research. The participants were asked to provide a written consent acknowledging that they freely decided to participate in the research. All participants were asked to sign and date the consent form (Appendix D).

The participants' interviews and the focus group were conducted within the premises of agency's two sites out of total ten sites. During the first year of this PhD research, I was an employee of the agency and therefore my research project was considered as a 'insider research' at an initial stage. During this first year, no interviews or focus group were conducted and no participants were approached. A written request was sent to the Chief Executive Officer during this time in relation to anonymous dataset for the quantitative strand. The agency followed strict data protection policies and has a nominated data controller officer. General Data Protection Regulations (GDPR, 2018) were not applicable and they were not introduced in 2015 at the time of data sharing. However, all data were shared in line with Data Protection Act (2010).

4.4.4 Withdrawal of consent

All participants (practitioners and clients) were given the opportunity to request that their data be destroyed/ withdrawn from a research project by using a security level 4 micro-cut shredder. I informed all participants about their right to withdraw with certain exceptions;

- 'Final results have already been published
- An individual's data is no longer identifiable (because of coding anonymity)
- An individual's data cannot be extracted from cohort analysis.'

(Loughborough.ac.uk, n.d.)

If it was not possible to withdraw an individual's data for any reason, I was responsible for explaining this to the participant. Fortunately, no such request was received during this study.

4.4.5 Confidentiality and its limitations

Confidentiality and privacy are the core ethical issues for any research project. According to Christians (2013), it is fundamental to any ethical research project to protect the identities of participating individuals and organisations.

All information obtained from the participants during the research was treated as confidential to the researcher and the supervisory team. All participants were informed about confidentiality and its limitations such as, in case of statutory obligations to disclose identity of participants in certain situation i.e.

- Drug trafficking and serious crime
- Terrorism
- Safeguarding concerns – children & vulnerable adults
- When required to do so by court.

During this research project no such situation occurred where any participant disclosed information in relation to above mentioned issues that required contacting any third party with or without their consents.

The nature of the research was communicated (in paper copy or read out if required and appropriate) to the participants through the information sheet and consent form.

At the end of the interview a debrief session ensured that the participants were informed that a copy of the published research summary could be sent to them in post or via email or it will be available from the agency's offices once the research is completed. Information sheet/consent forms had a specific section regarding dissemination of the research findings.

4.4.6 Data storage

Consent forms were stored in secure conditions i.e. in a locked cabinet situated in a locked room with no unauthorised access.

Consent forms and transcriptions of interviews were uniquely coded (i.e. initials/ gender/interview date/interview number for example, JB/M/101118/01 and were stored separately (from consent forms) and securely.

Participants' interviews and focus group were audio recorded, and the researcher transcribed the interview and focus group verbatim. The transcribed interviews were anonymized, that is, any identifiable information was removed. Extracts from the interviews have been quoted in this research, however no identifiable information have been included.

It is a common practice in qualitative research to include sections of transcripts in dissemination activities. I will ensure that any published information remains anonymous. In an exceptional case, if it becomes unavoidable to include a quote from a participant without identifying (to a certain level) the person because of their unique role in the agency, then I will seek further explicit consent from the concerned participant before including any such quote in publications and conference presentations.

In accordance with the Data Protection Act (GOV.UK, 1998) the electronic data were stored in a password protected and encrypted laptop (encrypted to AES256 - Advanced encryption standard) to safeguard against any unauthorised access. Data was backed up on encrypted USB drives – stored in a locked cabinet situated in a locked room with no unauthorised access. No CDs or DVDs were used to store data to ensure data protection.

4.4.7 Safety of researchers and participants:

All clients of the participating agency are risk assessed regularly and detailed risk management plans are developed by the agency. All practitioners were advanced DBS (Disclosure and Barring Service) checked and their DBS information was updated every three years. To ensure safety:

- All sessions were conducted at the agency's premises.
- The interview rooms were fitted with panic alarm systems and I familiarised myself with the safety rules.
- The researcher's supervisor details including contact details were provided to all participants to enable them to report any concerns about the researcher or for any other comments.

- All participants were encouraged to discuss with their line manager/HR personnel or practitioner (as appropriate) in case of any concerns or issues.

At the end of the interview a debrief session ensured that the participants could explore any concerns or issues. The consent form clearly indicated that the participants would have complete freedom to stop the recording, stop the interview, withdraw from the study, and refuse to answer any question or seek further clarification or information about the study at any time without having to explain why.

4.5 Reflexivity

Wilkinson (1988: 493) defines reflexivity as 'disciplined self-reflection' and it requires a commitment to an enduring self-awareness as a researcher (Finlay and Gough, 2003; Nicholson, 2003). It includes an initial internal congruent position about the research interest, the aims and objectives of the research study at its conception. Willig (2001) identifies two reflexive positions - an epistemological and personal perspectives. For Finaly (2012: 18) reflexivity is 'being thoughtfully and critically self-aware of personal/relational dynamics in the research'. Furthermore, Finaly (2012) proposes three levels of reflexivity; strategic, relational, and ethical. Strategic reflexivity includes a researcher's critical reflection on research aims, objectives, methodological perspectives, and overall research design (Finaly 2012). Relational reflexivity (Finaly, 2012) includes a researcher's awareness of relational dynamics during the data collection process such as, interviews. It is important to acknowledge that there is no neutral, complete unbiased and objective position as an interviewer (Nicolson, 2003). Ethical reflexivity means that a researcher is thoroughly and consistently aware of and compliant with ethical research practice (Finaly, 2012).

With the above discussion about reflexivity in mind, I endeavoured to engage in a reflective, transparent, phenomenological and honest attitude throughout this research project. Reflexivity is an aspirational goal and most researchers can only endeavor to work towards a goal of reflexive research practice. Reflexivity is not a destination, it is a long and painstaking journey in the service of enhanced quality controls of the study.

My epistemological position was informed by a phenomenological – pragmatist approach (for more discussion see 4.1.5). The phenomenological approach was mainly based on the work of Husserl and Merleau-Ponty (Spinelli, 2005). Husserl proposed the

phenomenological method of investigation on the basis that our experience of 'the world is a unique intentional construct containing both directional and referential foci' (Spinelli, 2005: 19). The phenomenological method is comprised of three unique yet connected rules:

i. The rule of epoché
ii. The rule of description
iii. The rule of horizontalisation

The rule of Epoché – to set aside or to bracket any biases, judgements, prejudices, assumptions and expectations 'in order to focus on the primary and immediate data of our experiences' (Spinelli, 2005: 20). He argues that it is not humanly feasible to bracket all our biases or assumptions, however, we are certainly capable of bracketing to a great extent as well as acknowledging our biases reduces their impact on our immediate experiences. The acknowledgement of bias, inherent in the phenomenological methods, is congruent with the notion of *a priori* themes in template analysis. Its only when we name our position clearly we are able to listen the 'other' or to something different.

The rule of description – which can be defined as 'description' instead of 'explanation'. This rule encourages us to suspend our desires to explain the other. It is to avoid limiting our experience of the other by instantly attempting to make sense or explain 'it' on the basis of our hypothesis. We are encouraged to focus on description instead of theoretical reasoning in order to achieve concretely based descriptive investigation of our intentional biases which make up our experience. The key principle is to stay close to our immediate experiences through the process of description (Spinelli, 2005). This principle supports the process of developing the initial '*a priori'* template.

The rule of horizontalisation – also known as equalization, encourages us to avoid assigning 'any initial hierarchies of importance upon the items of our descriptions, and instead to treat each initially as having equal value or significance' (Spinelli, 2005: 21). 'We set aside our preconceptions about what kinds of data are more significant than other kinds, thus remaining open to the possibility that some factors will prove – upon examination – to be more significant than we might formerly have thought' (Crocker, 2009: 22). The flexibility in template analysis to adjust the final template as the new or different information emerges during the process of initial coding supports the notion of horizontalisation.

Using template analysis (TA) to analyse the qualitative data further supported the essence of reflexivity and overall quality control. The mechanism of undertaking TA study shares the principles of phenomenological methods as discussed above. The phenomenological concepts of epoché and horizontalisation are inherent to the process of template analysis. The rule of epoché requires bracketing off personal biases and this is only possible through the position of enhanced self-awareness and acknowledging personal biases. Horizontalisation – treating all information equally important, is crucial to the process of TA, that is, to make appropriate changes to the thematic template as new information emerges. An '*a priori*' template supports the process of acknowledging the starting position of researchers in a transparent manner. Inherently, TA supports the process of audit trail, that is, consecutive versions of the template with supplementary commentary regarding any changes are available for audit process.

4.5.1 Personal reflection

I worked in the addiction field for over 20 years in a variety of different roles ranging from alcohol practitioner to senior management. I was mindful of my own biases, particularly during my early work as an alcohol counsellor in relation to clients' non-attendance, such as the clients are not motivated enough to attend their sessions, they lack commitment to change, and poor treatment compliance.

Over the time, my position shifted to some extent and I began to consider the impact of practitioners' skills and competencies on their clients' engagement. In addition, I was particularly mindful of the potential impact of my background as a psychotherapist on my role as a researcher particularly whilst conducting interviews and the focus group. As a therapist, my role is to explore clients' experiences (feelings, emotions, thoughts, sensations) with an intention to support them in relation to their challenging life experiences. On the other hand, as a researcher, my focus had to be on participants' experiences in relation to the subject matter in line with the aims and objectives of this research project.

The above-mentioned phenomenological methods (see section 4.5) supported my approach in this study as a researcher in the service of achieving and maintaining strategic, relational and ethical reflexivity (Finaly, 2012). In order to support my position as a

researcher and address the above-mentioned challenges, I used a range of support mechanisms such as weekly personal therapy to explore personal experiences and challenges during this study and to ensure the boundaries between psychotherapy and research were kept intact at all times. The personal therapy sessions helped me to acknowledge my preconceived ideas about clients' lack of commitment to change that impacted their attendance at their alcohol support sessions. The exploration of this belief, that clients' non-attendance is primarily related to clients' lack of motivation and commitment, served two functions – one, it was easier to 'blame' the clients instead of reflecting on my own motivation and commitment as an alcohol counsellor and second, it was a good cultural fit at work to avoid exploring clients' non-attendance as a relational response. I also discussed my progress and different aspects of this research with my Director of Studies on an ongoing basis. In order to maintain an open, transparent and reflective account of my work, I undertook the following steps;

- Post interview reflection form (Appendix G)
- Reflective journal (Appendix H)
- Regular discussions and supervision sessions with the research supervisory team – particularly at all milestones such as developing the interview guides, post interviews and focus group discussions, coding, both quantitative and qualitative analyses, initial templates (TA), and write up.
- Shared the step by step process of quantitative and qualitative data collection and analysis including SPSS worksheets and syntax files with the research supervisory team.
- Presentation of preliminary findings at different research conferences
- Presentation of preliminary findings to the senior management of the agency who's data were used in this study.

The process of completing post-interview reflection forms greatly supported me in reflecting on my experiences of exploring issues of non-attendance with practitioners. It helped me in naming my phenomenological experiences with each individual and paying attention to questions such as what did I learn from this experience, was I able offer a reflective space to my participants to explore their experiences, what went well and what

did not, how could I improve further, did I manage to maintain an open stance and not asked leading and closed questions, and what were the salient points of our interview. I recognised the significance of reflexivity early on in this research project and actively used research supervision meetings to help differentiate the discovery of knowledge and information based on data analysis, literature review, and my clinical practice. It is important to highlight that being both a practitioner and researcher also strengthened my position in this research because of having in-depth knowledge of the subject matter and having insight and empathy into clients and practitioners' experiences of non-attendance.

4.6 Chapter summary

This mixed methods research project used quantitative and qualitative methodologies to address the key aim of this study, that is, exploring reasons for clients' non-attendance at appointments within a community-based alcohol service. The quantitative strand was based on secondary analysis of an existing dataset and the qualitative strands were based on interviewing practitioners and a focus group comprised of clients. The quantitative data were analysed using chi square and binary logistic regression in order to determine predicting variable of clients' non-attendance. Template analysis was used to analyse the qualitative data. Ethical considerations, triangulation and reflexivity were discussed in this chapter. The chapter will present the results and discussion of quantitative strand.

Chapter 5 Results and Discussion – Quantitative Strand

The aim of the quantitative strand was to explore predicting factors related to clients' non-attendance at appointments within a community-based alcohol service. This was achieved by secondary analysis of an existing dataset from a community-based substance misuse service in the Midlands. The key research questions were: do clients' socio-demographic and clinical factors determine non-attendance, and do receipts of text message reminders and timing of the appointment determine non-attendance. The data comprised 194,679 treatment appointments detailing 22,405 clients' attendance history for four years (Jan 2010 – Dec 2013).

The data were analysed by hierarchical logistic regression to determine which factors can predict non-attendance. The aim of this analysis was to determine which factors are significantly associated with clients' non-attendance for treatment, including their socio-demographic, clinical history, SMS text message reminder, and event time variables. The data were also analysed using Chi-square analysis for the purpose of descriptive information (Appendix J). Correlational statistics were not suitable due to the nominal/categorical nature of the data (Schwartz et al., 2015). Chi-square analysis and logistic regression are commonly used with nominal data (categorical), which compares observed frequencies with expected frequencies (Hewitt and Cramer, 2010).

5.1 Hierarchical Logistic Regression to Determine Predictors of Non-Attendance

The clinical data were analysed using a hierarchical four-stage binary logistic regression model. Logistic regression was appropriate to determine which client factors predicted non-attendance, as the outcome variable is categorical with two levels (attended/non-attendance), which were coded as 0=attended, and 1-non-attendance. In hierarchical regression, variables or sets of variables are entered in stages (or blocks), so the researcher can assess what contribution each block of variables (e.g., sociodemographic factors, clinical history, SMS, event time) adds to predicting the outcome variable (non-attendance), after controlling for previous variables (Pallant, 2013). In addition, logistic regression accepts both continuous and categorical independent variables (Pallant, 2013). Field (2018: 879) describes logistic regression as 'model for predicting categorical variables from categorical and continuous predictors'. Table 5.11, Block 1 of the logistic model

analysed the impact of socio-demographic factors on non-attendance; Block 2 assessed the impact of clinical history factors on non-attendance; Block 3 tested the impact of receiving an SMS message reminder on non-attendance; and Block 4 analysed the impact of event time on client non-attendance. Logistic regression is commonly used in health and clinical research to identify what factors predict a client having one outcome over another (in this case whether or not a client did not attend).

5.1.1 Assumptions of logistic regression

Logistics regression tests models to predict categorical outcomes with two or more categories, where the independent variable can be either categorical or continuous, or a mix of both in the one model (Pallant, 2013). Burns and Burns (2008: 378) present the following list of assumptions of logistic regression.

- No linear relationship between the dependent and independent variables.
- The dependent variable must be a categorical.
- The independent variables need not be interval, nor normally distributed, nor linearly related, nor of equal variance within each group.
- The categories (groups) must be mutually exclusive and exhaustive.
- Larger samples are needed.

(Burns and Burns, 2008: 378)

Normality: Logistic regression does not require the assumption of normality (Burns and Burns, 2008).

Sample Size: A sample size of 10,367 was deemed adequate for logistic regression. According to Smeden et al. (2019) the minimum valid cases per variable should be minimum 10. Similarly, Peng (2017: 890) also 'recommended a minimum ratio of 10 to 1'. In this analysis, there are 10,367 valid cases and 15 independent variables. The ratio of cases to independent variables is 863.92 to 1, which satisfies the minimum requirement, and also the sample size assumption of logistic regression (Burns and Burns, 2008).

Multicollinearity: Multicollinearity is an important assumption in regression. Multicollinearity occurs when two independent variables are too highly correlated with one

another, which indicates that they may be measuring the same construct. There is no evidence of multicollinearity problems, as few of the independent variables in the logistic model had a standard error larger than 2.0 (Tabachnick and Fidell, 2001).

5.1.2 Interpreting Logistic Regression Odds Ratios

Table 5.1 presents the logistic regression results showing the B coefficients, the Wald statistics, significance p-values, odds ratios and 95 per cent confidence intervals for the odds ratios. An odds ratio of 1.000 indicates 'no change' in the likelihood of the outcome (non-attendance). An odds ratio value above 1.000 (if statistically significant) indicates an increased likelihood (odds) of the client not-attending. Conversely, an odds ratio value below 1.000, indicates a decrease in the likelihood of non-attendance. If the odds ratio value is below 1.000 (e.g., .746), it is converted to a percentage, by subtracting 1 - .746 = .254 (which is 25.4%), this would indicate that the client is 25.4% less likely to not attend. If the odds ratio is above 1.000 (e.g., 3.567), the client is over 3 times (or 35.6%) more likely to not attend. If the odds ratio is only slightly above 1.000 (e.g., 1.127), we look at the 95% confidence intervals for the odds ratio, if the lower odds ratio 95% CI is below 1.000, then the odds ratio is not reliable (Pallant, 2013).

5.1.3 Summary of Results: Significant Predictors of Non-attendance

The logistic regression results revealed that six socio-demographic factors significantly predicted non-attendance (youngest and oldest age group; ethnicity; current employment status; physical/mental health issues and unemployment; accommodation needs; young people in independent/supported housing; parental status (non-parent/non-nuclear family), and number of children (3 or 6 children reduced attendance). Two clinical history predictors of non-attendance were overall discharge reason, and risk level. Receiving an SMS reminder also predicted higher non-attendance. Finally, certain event times also increased non-attendance).

5.1.4 Testing the Impact of Sociodemographic Factors on Non-attendance

Block 1 (Table 5.1), which assessed the impact of sociodemographic variables was significantly reliable, chi-square (41, N=10367) = 297.201, p<.001), indicating that sociodemographic factors reliably predict non-attendance. The null hypothesis that there is

no difference between the model with only a constant (Block 0 with no predictors) versus the Block 1 model with sociodemographic predictors was rejected. The contribution of the relationship between the demographic predictor variables and non-attendance was supported. Statistical assumptions of Nagelkerke's R square are .043, which indicates that this model explained approximately 4.3% of the variation in non-attendance (Pallant, 2013). The sociodemographic model correctly predicted 99.9% of cases who attended, but only 0.9% of cases who did not attend. This suggests that the client's sociodemographic factors alone are not enough on their own to predict all variation in non-attendance, i.e., other factors that we consider in later Blocks of the model also contribute to the likelihood of non-attendance. The -2 log likelihood value was reduced in Block 1 (-2LL = 10874.487) compared with block 0 (-2LL = 11170.688), indicating that Block 1 (sociodemographic factors) predicts non-attendance better than the constant (Block 0 with no predictors).

5.1.5 Gender is Not a Significant Predictor of Non-Attendance

Although chi-square analysis found males were more likely to not-attend, the logistic regression analysis (Table 5.1) demonstrated that Gender was not a significant predictor of non-attendance; indicating that, over time there will be no trend in attendance rates by gender [OR = .392, p = .187, 95% CI for OR: .840-1.035]. The odds ratio implies that there is a different between genders, but the p value indicates that is not significant.

5.1.6 Age Group Significantly Predicts Non-Attendance (18-24 and 75+ years)

Age was a significant predictor of non-attendance. 18-24-year olds were used as the comparison group. Overall, the results (Table 5.1 below) indicated that the youngest age group 18-24 were the most likely to not attend. Compared to this 18-24 age group, the logistic regression results revealed that, older clients aged 65-74 years were 63% less likely to not attend [OR = .368, p = .001, 95% CI for OR: .22-.616]; clients aged 55-64 years were 46% less likely to not attend [OR = .539, p = .001, 95% CI for OR: .416-.699]; clients aged 45-54 years were 37% less likely to not [OR = .63, p = .001, 95% CI for OR: .511-.777]; clients aged 35-44 years were 24% less likely to not attend [OR = .764, p = .009, 95% CI for OR: .625-.934]; and clients aged 25-34 years were 22% less likely to not attend [OR = .781, p = .018, 95% CI for OR: .636-.958]. Conversely, the oldest age group, clients aged 75+ years

were no more or less likely to attend than the comparison group of 18-24-year olds. This means older age groups were more like to attend than younger age groups.

5.1.7 Ethnicity Significantly Predicts Non-Attendance

Ethnicity was a significant predictor of non-attendance. White British clients were used as the comparison group. Overall, the results (Table 5.1 below) indicated that White British clients were less likely to not attend than any other ethnicity group except Chinese clients. Bangladeshi clients were more likely to not attend [OR=1.867, p=.001, 95%Cl for OR: 1.407-2.478].

5.18 Current Employment Status Significantly Predicts Non-Attendance

Clients in 'Regular Employment' were used as the comparison group, as employment is the optimal employment status for clients. Results revealed that clients who were homemakers were 0.673 times less likely to not attend (1.000 - .673 = 0.327 or 32.7%). However, clients who received ESA (Employment Support Allowance) were 1.793 times more likely to not attend [OR = .1.793, p = .001, 95% CI for OR: 1.502-2.141]. Clients who were 'Economically Inactive due to Mental ill health' were 1.633 times more likely to not attend [OR = 1.633, p = .009, 95% CI for OR: 1.129-2.36] and clients on Long term sick or disabled were 1.545 times more likely to not attend [OR = 1.545, p = .001, 95% CI for OR: 1.324-1.804]. Clients on Job Seekers Allowance were 1.403 times more likely to not attend [OR = 1.403, p = .001, 95% CI for OR: 1.17-1.682]. The results suggest that health issues affecting employment status, also increase non-attendance, as does being unemployed on job-seekers allowance.

5.1.9 Accommodation Needs Significantly Predict Non-attendance

'Clients with a Housing Problem' were used as the comparison group. Clients with 'No Housing Problem' were 0.835 times (16.5%) less likely to DNA; whereas clients categorised as an 'Independent Young Person in Settled Accommodation' were over five times more likely to not attend [OR = 5.406, p = .016, 95% CI for OR: 1.362-21.455]. This factor has the highest odds ratio of all factors considered in this study, indicating that being a young independent person in settled accommodation is the biggest predictor of non-attendance. Clients categorized as a Young Person in Supported Housing were also 3.105 times (69%)

more likely to not attend. It is possible that both of these groups are in the young 18-24 age group, which is the age group most likely to not attend.

5.1.10 Parental Status Significantly Predict Non-attendance

'Clients who have all the children living with them' were used as the comparison group. The client was 1.528 times more likely to not attend when 'Some of the children Live with them'; was 1.521 times more likely to not attend when 'None of the children live with them', and was 1.317 times more likely to not attend when 'Not a parent'. The results suggest that clients who are living with all children are more likely to attend, which may be a sign of more stability and more functioning life, than clients with only some children (the family has been broken up), or no children/not a parent are more likely to not attend. It could be tentatively concluded that clients with better functioning families are more likely to attend.

5.1.11 Number of Children Living with Client is A Significant Predictor

'Clients with 0 children living with client' were used as the comparison group. Results revealed that the client was 2.799 times more likely to not attend if 'Six children live with the client', and is 1.521 times more likely to not attend, if 'Three children live with the client'.

5.1.12 Testing the Impact of Clinical History Factors on Non-Attendance

Block 2 of the logistic regression (Table 5.1) which assessed the five clinical historical factors was also significantly reliable, chi-square (60, N=10,367) = 861.849, p<.001). It indicated that the client's clinical history also reliably predicted non-attendance. Nagelkerke's R square is .121, indicating that this model explained approximately 12.1% of the variation in non-attendance. Clinical history factors correctly predicted 97.9% of clients who attended, and 7.5% of clients who did not attend, which is an improvement on the sociodemographic factors in Block 1, which correctly predicted only .9% of clients who did not attend. The -2 log likelihood value of 10308.839 reduced further in block 2 compared with block 1, indicating that client's clinical history is a better predictor of non-attendance than just sociodemographic variables.

5.1.13 Overall Discharge Reason Significantly Predicts Non-Attendance

The agency used two discharge categories in relation clients exiting the service, i) 'internal discharge' discharge from one aspect of the treatment such as tier 3 to tier 2 ii) the 'final discharge' from the agency that is noted as 'Overall Discharge Reason'. The impact of Overall Discharge Reason on DNA was included to determine retrospectively, which former client had any issue with DNA during their treatment period. The reference category was 'Did Not Contact' (that is, client did not make any contact with the service after the initial referral – mainly referred by other professionals). The results revealed that the following categories within 'Overall Discharge Reasons' significantly predicted clients' non-attendance:

- Treatment completed – alcohol-free when the risk of non-attendance was significantly reduced by 74%;
- Treatment completed – occasional user when the risk of non-attendance was reduced by 69.7%;
- Transferred (client) – in custody when the risk of non-attendance reduced by 62.2%;
- Transferred (client) – not in custody when the risk of non-attendance reduced by 61.9%.

These results indicate that clients who successfully complete treatment alcohol or drug free, were less likely to DNA during the treatment.

5.1.14 Clinical Risk Level Significantly Predicts Non-attendance

Clients were risk-assessed against following categories – domestic abuse, medication abuse, risk to or neglect of children, neglect/vulnerability, abilities to care for the child as a parent or carer, pregnancy, risk to staff, self-harm, suicide, violence, harm to others, health (e.g. fits, blackouts, withdrawals).

The reference category was the 'High Risk' client. The results revealed that a client was 31.7% less likely to DNA when they were 'No Risk' (reported/assessed) (i.e., 1-.683 = .317) [OR = .683, p = .003, 95% CI for OR: .53-.881]; 23% less likely when 'Low Risk' (i.e., 1-.770 = .230) [OR = .77, p = .001, 95% CI for OR: .663-.896]; and 13.4% less likely to DNA when 'Medium Risk' (1 - .866 = .134, or 13.4%) [OR = 1.444, p = .008, 95% CI for OR: 1.099-1.897].

5.1.15 Smoking Status: Not a Significant Predictor

Smoking status did not significantly predict DNA [p = .063], using a reference category of 'Never Smoked' to compare against 'Current Smokers' and 'Ex-smokers'. This result indicates that 'Ex-smokers' and 'Current Smokers' are equally likely to DNA as clients who 'Never Smoked'.

5.1.16 Pregnancy Status: Not a Significant Predictor

The reference category was 'Not Pregnant'. Pregnancy status did not predict DNA, although it approached significance [OR = 1.747, p = .066, 95% CI for OR: .964-3.165]. Therefore, in this sample, pregnant women were as equally likely to DNA as non-pregnant women.

5.1.17 Dual Diagnosis: Not a Significant Predictor

The reference category was 'No Dual Diagnosis'. Having a dual diagnosis did not predict DNA [OR = .984, p = .780, 95% CI for OR: .880-1.100]. This means that clients with a dual diagnosis were equally likely to DNA, as clients without a dual diagnosis.

5.1.18 Testing the Impact of Receiving an SMS Message Reminder on Non-Attendance

The third full model (Table 5.1, Block 3) which considered the impact of a client receiving an SMS reminder message on whether or not they did not attend, was significantly reliable, chi-square (61, N=10,367) = 873.535, p<.001), therefore this predictor variable reliably predicted whether or not a client did not attend. Nagelkerke's R square is .123, therefore this model explained approximately 12.3% of the variation in DNA; and this model correctly predicted 97.9% of attendance, and 8.4% of cases who did not attend, which is a further improvement on the model in Block 2. The -2 log likelihood was lower in Block 3 (10297.163) than Block 2, indicating that receipt of an SMS reminder is a better predictor of whether a client did or did not attend than the demographic or clinical predictor variables.

The comparison group was No (i.e. SMS message reminders were not received). This result revealed that receiving an SMS message reminder predicted that a client did not attend [OR = 1.262, p = .001, 95% CI for OR: 1.106-1.440]. Therefore, receiving an SMS reminder is associated with not attending the treatment event time, compared with those who did not receive an SMS reminder. However, it should be noted that only 12.1% of the study sample

(N=23564) did receive an SMS reminder, whereas 87.9% of the study sample did not (N=171115). Therefore, the negative affect of the SMS reminder on increasing the likelihood of DNA in this sample, should be interpreted with caution. Obviously, the real effect of the SMS reminder cannot be determined until the majority of the clients do receive SMS message reminders.

5.1.19 Testing the Impact of Event Time on Non-Attendance

The fourth and final full model (Table 5.1, Block 4) which considered event time (appointment time) as the independent variable was significantly reliable, with chi-square (81, N=10,367) = 926.197, p<.001), indicating that 'Event Time' reliably predicted whether or not a client did not attend. Nagelkerke's R square is .130, indicating that this model explained approximately 13% of the variation in DNA; and this model correctly predicted 97.7% of attendance, and 9.1% of cases who did not attend. The -2 log likelihood was lower in Block 4 (10244.491) than Block 3 (Table 5.1), indicating that event time is a better predictor of DNA than the predictor variables considered in block 1, 2 and 3 (Table 5.1).

The event time of 9.30-9.59am was the comparison group as this event time is the most frequent event time for our clients. Two of the event times increased the likelihood of DNA: The 15.30-15.59pm event time increased the likelihood of DNA by 1.265 times; and the 11.00-11.29am slot increased the likelihood of DNA by 1.188 times. In contrast, three event times reduced the likelihood of DNA: The 11.30-11.59am event time reduced DNA by 74.5% (1 - .255 = .745), the 10.00-10.29am event time reduced DNA by 38.5% (1 - .615 = .385); and the out of hours event times reduced DNA by 28.1% (1 - .719 = .281). See Table 5.11, Block 4 for odds ratios and p values.

Table 5.1 Hierarchical logistic regression results predicting non-attendance with socio-demographic, clinical history, SMS message reminder, and event time.

Block 1 (Table 5.1)							
Variable	Category	*B*	Wald	p-value	Odds Ratio	95% CI for OR Lower	95% CI for OR Upper
SOCIO-DEMOGRAPHIC PREDICTORS (BLOCK 1)							

Gender	Female=0,	-.07	1.738	.187	.932	.84	1.035
	18-24 years is the comparison group		36.124***	.001			
Age Group	25-34 years	-.247	5.62*	.018	.781	.636	.958
	35-44 years	-.269	6.923**	.009	.764	.625	.934
	45-54 years	-.462	18.698***	.001	.63	.511	.777
	55-64 years	-.617	21.782***	.001	.539	.416	.699
	65-74 years	-1	14.459***	.001	.368	.22	.616
	75+ years	-.824	3.227	.072	.439	.179	1.078
Ethnicity	White British		457.082***	.000			
	Bangladesh	.624	18.707***	.000	1.867	1.407	2.478
	Caribbean	.356	75.191***	.000	1.427	1.317	1.546
	Chinese	-1.535	11.008***	.001	.216	.087	.534
	Indian	.141	22.750***	.000	1.152	1.087	1.221
	Not stated	.305	35.908***	.000	1.356	1.228	1.498
	Other	.479	52.024***	.000	1.615	1.417	1.839
	Other Asia	.345	28.454***	.000	1.412	1.244	1.602
	Other Black	.092	2.913	.088	1.096	.986	1.218
	Other mixed	.587	124.631***	.000	1.798	1.622	1.993
	Other white	.126	3.198	.074	1.135	.988	1.303
	Pakistani	.214	4.940*	.026	1.238	1.026	1.495
	White/Asian	.322	63.482***	.000	1.381	1.275	1.494
	White / black african	.497	44.647***	.000	1.643	1.420	1.901
	White/black carribean	.198	38.755***	.000	1.220	1.146	1.298
Current Employment Status	Regular Employment is the comparison group		87.019***	.001			
	Economically Inactive	.49	6.799**	.009	1.633	1.129	2.36
	Employment Support	.584	41.648***	.001	1.793	1.502	2.141
	Homemaker	-.396	4.23*	.040	.673	.462	.982
	Job Seekers Allowance	.339	13.394***	.001	1.403	1.17	1.682
	Long term sick or	.435	3.36***	.001	1.545	1.324	1.804
	Not receiving benefits	.271	3.147	.076	1.311	.972	1.768
	Pupil/Student	-.249	.609	.435	.779	.417	1.458
	Carer	.117	.135	.713	1.124	.602	2.098
	Retired from paid work	-.042	.041	.839	.959	.642	1.432
	Unemployed	.606	2.778	.096	1.832	.899	3.735
	Unemployed and	.149	3.896*	.048	1.161	1.001	1.346
	Unpaid voluntary work	-1.193	6.472**	.011	.303	.121	.761
	Work Programme or	-.589	0.88	.348	.555	.162	1.9
Accommodation Need	Reference Category: Housing problem		31.258***	.001			
	Independent YP -	1.687	5.756*	.016	5.406	1.362	21.455
	Independent YP -	.396	.894	.344	1.486	.654	3.38
	Independent YP with No	21.892	0	.999	3.22E+09	0	
	NFA - urgent housing	.176	1.931	.165	1.193	.93	1.53
	No housing problem	-.181	8.969**	.003	.835	.742	.939
	YP living in care	22.114	0	1.000	4.02E+09	0	
	YP living with relative	2.104	3.175	.075	8.196	.81	82.885
	YP supported housing	1.133	3.942*	.047	**3.105**	1.015	9.502
Parental Status	Reference Category: All the children live with		21.704***	.001			
	Children living with	.313	.077	.781	1.367	.151	12.365
	Client declined to	.244	.044	.834	1.277	.129	12.593
	No children	.929	3.103	.078	2.533	.901	7.126

	None of the children	.42	9.563**	.002	1.521	1.166	1.985
	Not a parent	.276	3.777*	.052	1.317	.998	1.739
	Some of the children	.424	9.095**	.003	1.528	1.16	2.013
	Reference Category: 0 children		12.424	.087			
Number of children living with client	1	-.016	.014	.907	.984	.746	1.297
	2	.033	.05	.823	1.033	.776	1.376
	3	.419	5.429*	.020	1.521	1.069	2.164
	4	.036	.025	.875	1.036	.664	1.619
	5	.031	.011	.916	1.031	.579	1.836
	6	1.029	4.936*	.026	2.799	1.129	6.938
	7	-2.475	0	1.000	0	0	

Note. OR=odds ratio *p<.05, **p<.01, ***p<.001.

Block 2 (Table 5.1)

Variable	Category	*B*	Wald	p-value	Odds Ratio	95% CI for OR Lower	95% CI for OR Upper
CLINICAL HISTORY PREDICTORS (BLOCK 2)							
Smoking status	Never Smoked is the comparison group		5.533	.063			
	Ex-smoker	-.025	.066	.797	.975	.807	1.178
	Current smoker	.125	2.838	.092	1.133	.98	1.309
Pregnant(1)	Reference Category: No=0, Yes=1	.558	3.384	.066	1.747	.964	3.165
Dual Diagnosis(1)	Reference Category: No=0, Yes=1	-.016	.078	.780	.984	.88	1.1
Overall Discharge Reason	Reference Category: Did Not Contact		473.806	.000			
	Dropped out/left	-.812	.294	.588	.444	.024	8.346
	Incomplete - client died	-.819	6.666	.010	.441	.237	.821
	Incomplete - dropped out	-.209	.905	.341	.811	.527	1.249
	Incomplete - retained in custody	-.798	4.965	.026	.45	.223	.908
	Incomplete - treatment commencement declined by client	.169	.536	.464	1.184	.753	1.863
	Incomplete - treatment withdrawn by provider	-.918	1.759	.185	.399	.103	1.55
	Transferred - in custody	-1.055	16.614	.000	.348	.21	.578
	Transferred - not in custody	-.964	17.452	.000	.381	.243	.599
	Treatment completed - alcohol-free	-1.347	36.728	.000	.26	.168	.402
	Treatment completed - drug-free	-1.295	18.619	.000	.274	.152	.493
	Treatment completed - occasional user (not opiates or crack)	-1.196	29.16	.000	.303	.196	.467

	Reference Category: High risk		3.504	.000			
Risk Level	Low Risk	-.261	11.486	.001	.77	.663	.896
	Medium Risk	-.144	4.288	.038	.866	.756	.992
	No Risk	-.381	8.656	.003	.683	.53	.881
	Not Risk Assessed	.368	6.978	.008	1.444	1.099	1.897

Note. OR=odds ratio *p<.05, **p<.01, ***p<.001.

Block 3 (Table 5.1)

Variable	Category	*B*	Wald	p-value	Odds Ratio	95% CI for OR Lower	95% CI for OR Upper
SMS TEXT MESSAGE PREDICTOR (BLOCK 3)							
SMS	Yes=1, No=0 is the comparison group, as most clients said No	.233	11.904***	.001	1.262	1.106	1.44

Note. OR=odds ratio* p<.05, **p<.01, ***p<.001.

Block 4 (Table 5.1)

Variable	Category	*B*	Wald	p-value	Odds Ratio	95% CI for OR Lower	95% CI for OR Upper
EVENT TIME PREDICTOR (BLOCK 4)							
Event Time	9.30-9.59 is the comparison group (as it is the most frequent event time)		46.234***	.001			
	9.00-9.29	.088	.142	.706	1.092	.691	1.726
	1.00-1.29	-.487	3.691	.055	.615	.374	1.01
	1.30-1.59	-.172	1.972	.160	.842	.662	1.071
	11.00-11.29	.172	3.901*	.048	1.188	1.001	1.408
	11.30-11.59	-1.366	6.675**	.010	.255	.09	.719
	12.00-12.29	.089	.692	.406	1.093	.886	1.348
	12.30-12.59	.13	1.889	.169	1.139	.946	1.372
	13.00-13.29	-.773	2.452	.117	.462	.176	1.215
	13.30-13.59	.075	.325	.568	1.077	.834	1.392
	14.00-14.29	.038	.181	.670	1.039	.872	1.238
	14.30-14.59	-.489	1.477	.224	.613	.279	1.349
	15.00-15.29	-.086	.602	.438	.917	.738	1.141
	15.30-15.59	.235	4.512*	.034	1.265	1.018	1.57
	16.00-16.29	-1.393	3.377	.066	.248	.056	1.097

16.30-16.59	-.14	.16	.689	.869	.437	1.728
17.00-17.29	.152	.688	.407	1.164	.813	1.666
17.30-17.59	.642	.693	.405	1.9	.419	8.605
18.00-18.29	-.228	.654	.419	.796	.458	1.383
18.30-18.59	-.416	.952	.329	.66	.286	1.522
Out of Hours	-.329	3.892*	.049	.719	.519	.998

Note. OR=odds ratio *p<.05, **p<.01, ***p<.001.

5.2 Discussion

The secondary analysis was conducted on an existing dataset comprising 194,679 treatment appointments detailing 22,405 clients' attendance history for four years (Jan 2010 – Dec 2013). This is the largest study on this topic. No other published research has used such an extensive dataset in this area of investigation – reasons for clients' non-attendance at a community-based alcohol agency.

The aim of this quantitative strand was to explore factors predicting clients' non-attendance at appointments within a community-based alcohol service. The key research questions were; do clients' socio-demographic and clinical factors determine non-attendance and do receipts of text message reminders and timing of the appointments determine non-attendance.

The data were first analysed using chi-square analysis followed by hierarchical logistic regression to determine which factors could predict non-attendance. The aim of this analysis was to determine which factors were significantly associated with clients' non-attendance for treatment, including their socio-demographic, clinical history, SMS text message reminder, and event time variables. the p value for the chi square tables is showing the significance between the DNA and attendance variable rather than the relationship between the independent variables. But the breakdown of ind. variables across the two outcomes is giving descriptive information.

Chi-square (X^2) analysis was performed for descriptive information (Appendix J). These factors included; age, gender, parental status, ethnic origin, smoking, type of session, location of the service, employment status, smoking status and risk levels. The following Table 5.2 summarises the high and low DNA rates of the key client related factors;

Table 5.2 Summary of chi square analysis

Factors	High DNA (Low attendance rate)	Low DNA (High attendance rate)
Age	18-24 years old (37.8%)	55-64 years old (19.0%) 65-74 years old (14.0%)
Gender	Male (28.6%)	Female (24.1%)
Parental status	Declined to answer (30.1%)	All the children live with client (19.6%) Some children reside with client (21%)
Ethnic origin	Bangladeshi (37.6%) Pakistani (36.7%)	Chinese (6.5%) White British (24.5%)
Smoking	Current smoker (23.7%)	Never smoked (16.4%) Ex-smoker (17.8%)
Discharge reason	Treatment completed – Alcohol free (14%)	No contact after initial assessment (82.5%)
Session type	Arrest referral (60.9%) Assessment (40%)	Family session (5.4%)
Site/Team	Team 1 (32.7%)	Team 3 (9.3%)
Employment status	NEET (35%)	Retired from paid work (10.8%)
Risk levels	Not risk assessed yet (59.8%)	Low risk (20.3%)

*NEET = Not in Education, Employment, or Training

The data were analysed using a hierarchical four-stage binary logistic regression model. Block 1 (Table 5.1) of the logistic model analysed the impact of socio-demographic factors on non-attendance; Block 2 (Table 5.1) assessed the impact of clinical history factors on non-attendance; Block 3 (Table 5.1) tested the impact of receiving an SMS message reminder on non-attendance; and Block 4 (Table 5.1) analysed the impact of event time on client non-attendance.

The logistic regression results revealed that five socio-demographic factors significantly predicted non-attendance (i.e. youngest and oldest age group, current employment status: physical/mental health issues and unemployment; accommodation needs: young people in independent/supported housing; parental status (non-parent/non-nuclear family); and number of children: 3 or 6 children reduced attendance. Two clinical history predictors of non-attendance were overall discharge reason and risk levels. Receiving an SMS reminder also predicted higher non-attendance. Finally, certain event times (mainly afternoon sessions) also increased non-attendance.

The findings of this study presented new information about the predicting factors for the clients' non-attendance. No previous alcohol-focused study considered factors like time of the appointment, text message reminders, number of children, dual diagnosis, pregnancy, smoking, and clinical risk levels, in relation to clients' engagement or attendance. This study also included variables previously studied and many findings are consistent with the previous research literature. The research studies such as Siqueland et al. (1998), King and Canada (2004), Coulson et al. (2009), Palmer et al. (2009), and Deane et al. (2011) highlight a range of variables, for example, younger age, less education, unemployment, transport and financial issues, and logistical issues linked to a higher percentage of clients' non-attendance or non-engagement.

Siqueland et al. (1998) studied predictors of drop out from psychosocial treatment of cocaine dependence and they suggested that younger clients were less likely to attend their appointments. King and Canada (2004) reported two variables - gender (female) and ethnicity (African American) as independent predictors of early drop out. Jackson et al. (2006) identified a range of factors associated with commencement of treatment such as older age, living with others, drinking fewer alcohol units per day, no illegal drug use and shorter waiting times between assessment and the first appointment. Palmer et al. (2009) investigated both perspectives – clients and clinicians - and they reported that both groups highlighted a range of issues related to clients' early dropout such as heavy drug/alcohol use, financial issues, transportation problems and ambivalence about abstinence. Next, I will discuss different predicting factors for clients' non-attendance.

5.2.1 Age

This study shows that younger clients (18-24) were more likely to not attend their appointments. The DNA rate was 37.8% for 18-24 years old compared to 14% for 65-74 years old group. This table also shows a gradual decrease in DNA rates as the age increases with an exception of some minor increase in 75+ year group (14.3%). Previous studies (Siqueland et al. 1998; King & Canada, 2004; Booth & Bennett, 2004) support the current findings that age is an important associated factor in relation to clients' attendance, that is, younger clients are more likely to not attend their appointments.

Age and employment status demonstrate similar results, that is, younger people were more likely to DNA. For example, the NEET (Not in education, employment, or training) group has higher DNA rate (35%). The NEET group age range 16-24 years old (ONS, 2019) was somewhat identical to the above age-range group and both groups have highest DNA rates in their respective tables. Similarly, it can be assumed that 65-74 years (lowest DNA rate in the age-based analysis) were retired from work group that had lowest DNA rate (10.8%) – see Table 5.2.

According to national smoking prevalence statistics (NHS, 2019) younger age groups (18-24, 25-35) were most likely to smoke compared to over 65. Therefore, it could be argued that smoking status and age range chi square analysis are consistent, that is, younger people who were also more likely the current smokers had higher DNA rates compared to older client groups who were more likely non-smokers or ex-smokers.

Logistic regression analysis shows that clients with 'Independent Young Person in settled accommodation status' were over 5 times more likely to not attend (OR=5.406). This factor has the highest odds ratio of all factors considered in this study, indicating that being a young independent person in settled accommodation was the biggest predictor of non-attendance. Clients in Young Person supported housing were also 3.105 times more likely to not attend. It is possible that both of these groups are in the young 18-24 age group, which was the age group most likely to not attend.

It is important that the alcohol practitioners offer age appropriate interventions to improve young peoples' treatment engagement and attendance. This requires offering a multi-dimensional treatment plan that includes working in partnership with other support

providers such as housing, education, training, and employment. For further discussion and practice implications – see Chapter 8.

5.2.2 Ethnicity

This research demonstrates that ethnic minority clients, particularly Bangladeshi and Pakistani origin clients, were more like to DNA compared to White clients. BAME clients were more likely to not attend psychological or talking therapies (Department of Health, 2007). The lack of BAME clients' engagement with emotional or mental health and social care services is well documented in the previous studies (Leowenthal et al., 2012; Greenwood et al., 2015; Greenwood et al., 2017). Emotional, mental and social care professionals' lack of understanding of cultural factors of ethnic minority clients negatively impact their accessibility and engagement (Leowenthal et al., 2012). In addition, negative impact of language barriers also contribute to ethnic minority clients' lack of engagement with psychological services (Costa, 2011).

This study confirms the findings of Arfken et al. (2001) and King and Canada (2004) that ethnicity and gender differences are significantly related to clients' likelihood of non-attendance at treatment. In those studies, females and people from ethnic minority groups were likely to drop out or not attend their appointments (King and Canada, 2004) and African American clients were more likely to drop out compared with their White counterparts (Mccaul et al., 2001).

The previous research body offers mixed findings in relation to ethnicity and treatment engagement. Korte et al. (2011) and Acevedo et al. (2015), both studies based in the USA, suggest that their data show no statistical differences across different racial groups. This is perhaps due to lack of generalisability (Polit and Beck, 2010) in these cases as the USA and the UK have different cultures. Mccaul et al. (2001) suggest that ethnicity plays an important role in clients' treatment engagement. The UK-based research studies looking at alcohol treatment initiation and retention predictors (Booth & Bennett, 2004; Jackson et al., 2006) did not include ethnicity as one of their clients' demographic data. It is somewhat surprising that Jackson et al. included a range of demographics such as age, sex, employment and marital status but did not include ethnicity. Lack of acknowledgment of ethnicity could be linked to the notion of a 'colour blind' approach followed by many White

services and White researchers where racial ignorance and White privilege practices are prevalent (Bonilla-Silva, 2015; Jayakumar and Adamian, 2017).

This research is consistent with Lo and Cheng (2011) findings that White clients are more likely to attend their treatment appointments compared to any other ethnic group. This research shows that Bangladeshi (37.6% DNA) and Pakistani (36.7% DNA) were more likely to not attend their appointments compared to White British (24.4% DNA). Intersectionality (Crenshaw, 1989) has received a lot of attention in the recent years. Issues of difference such as age, gender, sexuality, race/ethnicity, religion, ability and class are inseparable within a person (Bhopal and Preston, 2012; Collins and Bilge, 2016). It could be argued that higher DNA rates among Bangladeshi and Pakistani client groups was not solely linked with being 'Asian' but probably also linked with their faith/religion – Islam. The current study shows a significantly lower DNA rate (27.1%) among the Indian client group who share a similar ethnic background – Asian and come from a similar geo-political environment i.e. South East Asia. This inter-racial difference could be linked to an important factor –Islam. Islam forbids alcohol (Qur'an 2:219). Both Pakistan (96%) and Bangladesh (90%) are Muslim majority countries.

Many Muslim majority countries have low recorded consumption of alcohol (Al-Ansari et al., 2015). On the one hand, religious forbiddance can act as a deterrent and on the other hand, strong religious introjects may be linked with social stigma in relation to accessing addiction treatment services. Al Ghaferi, Bond and Matheson (2017) suggest a 'biopsychosocial-spiritual model' in an Islamic context including a spiritual dimension in engaging with Muslim clients. Miller (1998) supports this idea and suggests including spirituality in addiction treatment.

The second highest DNA percentage group was Black/African/Caribbean (average 33.4%). Issues related to barriers to accessing health among Black clients are well recorded (Memon et al., 2016; Alang, 2019). Memon et al. (2016), a UK based qualitative study, conducted two focus group comprised of 26 black and minority ethnic adults. They (Memon et al., 2016) reported that participants identified two main themes in relation to black and minority ethnic clients attending mental health services. On the one hand, it included; personal and situational factors such as, lack of awareness and acknowledgement of mental

health issues, good use of social support network, men's reluctance towards seeking help, social stigma and financial challenges (Memon et al., 2016). On the other hand, factors affecting the relationship between clients and service providers included; language barriers, long waiting times, lack of effective communication between service providers and clients, lack of appropriate recognition or response to black and minority ethnic clients' mental health needs, power imbalance and perception of authority, lack of understanding of cultural histories, lack of sensitive, and racial discrimination (Memon et al., 2016).

Loewenthal et al. (2012) conducted a qualitative study exploring barriers to accessing psychological therapies based on eight focus groups with four ethnic minority client groups, that is, Bengali, Somali, Tamil, and Urdu speaking community groups. Two focus groups were conducted with Bengali speaking clients, one group consisted of eight female participants and the second group consisted of four females and two male participants. Two focus groups were conducted with Urdu speaking clients, one group consisted of 15 females and the second group consisted of six male participants. Two focus groups were conducted with Tamil speaking clients, one group consisted of 10 males and the second group consisted of eight female participants. Two focused were conducted with Somali speaking clients, one group consisted of 14 females and the second group consisted of 10 male participants. Loewenthal et al. (2012) used Braun and Clarke's (2013) thematic analysis to analyse the data. They reported the following key themes; importance of understanding of mental health issues and mental health services available to clients, cultural barriers to approaching mental health services, language barriers to accessing services, and significance of religion in clients' lives and its potential on accessing mental health services (Loewenthal et al., 2012). They conclude that 'further education at a community level could be useful in promoting services, alongside promoting mental health issues, and in turn, decreasing the associated stigma' (Loewenthal et al., 2012: 62).

Treatment services need to develop a well informed and culturally competent workforce that can offer empathic and inclusive services to all their clients. Colour blindness and unconscious repression of historic and contemporary racism could only lead to further mistrust and disengagement. For further discussion and practice implications – see Chapter 8.

5.2.3 Smoking and Other risk factors

There are no previous published research studies specifically exploring certain variables covered in this research such as smoking and risk levels (based on risk assessment of certain aspects such as; suicide, health, offending history and harm to self or others). It can be argued that clients with higher risk issues had multiple needs such as severe mental health issues and therefore would have found it difficult at times to attend their appointments. Bien and Burge (1990) suggest that smoking (nicotine) seems to expedite alcohol intake and vice versa. A study conducted by Friend and Pagano (2005) suggests that the clients who stopped their smoking consumed less alcohol compared to those who continued smoking. They also suggest that smoking cessation positively impacted reduction of alcohol intake, that is, reduced their alcohol intake. On this basis, addressing clients' smoking habits and mental health needs is crucial to clients' engagement and attendance rates.

5.2.4 Sites/Use of family interventions

Due to confidentiality the actual names of different sites have been removed (Table 5.2) making it difficult to offer any meaningful information about any specific reasons for different DNA rates across different sites. Site 1 and Site 2 have the highest DNA rates (32.7% and 29.6% respectively) whereas Site 3 had the lowest DNA rate at 9.3% compared to other sites. The average DNA rate across the service is 27%. Site 1 is the largest project (74,389 appointments) compared to Site 3 (3,331 appointments), however, Site 3's low DNA rate is significantly lower. The key difference between Site 3 and all other sites was the use of Social Behaviour and Network Therapy (Copello et al., 2002; Copello et al., 2006) and family interventions (Copello et al., 2005) with all clients. The Site 3 service manager was one of the senior practitioners who was trained by the UK Alcohol Treatment Trial team (UKATT Research Team, 2005; Orford et al, 2009) in delivering and providing training to other colleagues in family interventions and Social Behaviour and Network Therapy. UKATT was a national multi-centre randomized control trial of alcohol treatment in the UK comparing the effectiveness of SBNT and Motivational Enhancement Therapy on alcohol clients (UKATT research team, 2005). Site 3 also included family interventions in their service level agreement with their service commissioners. The client demographics of Site 3 were very similar to the agency's other sites, that is, all 10 sites of the agency were located

within 30 miles radius in the West Midlands. In my opinion, the embedded use of family interventions at Site 3 was the key factor that significantly reduced the DNA rate. Copello et al. (2002) highlighted the significance of involving family members/significant others in the drinker's treatment particularly in relation to bringing drinkers into treatment. The success of Site 3 supports Copello et al.'s (2002) assertion that a supportive social network significantly improves the recovery process for the person seeking treatment for alcohol problems. This finding has implications for clinical practice and service commissioning policies, that is, involving family members/significant others should be included in all service level agreements. It should be considered as a standard clinical practice instead of a specialised service.

5.2.5 SMS reminders

Previous studies strongly support the hypothesis that receiving text message reminders about appointments increases clients' attendance at health service appointments (Perron et al. 2013; Gurol-Urganci et al, 2013; McLean et al. 2016; Robotham et al., 2016; Tofighi et al., 2017). In this research the opposite was true. The logistic regression analysis shows receiving text message reminders predicted non-attendance. This anomaly can be explained.

The main issue was that only 12.1% of the study sample were sent text message reminders. The second issue with the existing data was about the target audience of SMS reminders. The SMS reminders were only sent to those clients with known history of non-attendance. This study is based on the dataset from Jan 2010-Dec 2013 and the service provider implemented automatic universal text message reminders to all clients during 2013. Until that time the text message reminders were only sent to those specific clients who had repeatedly missed appointments in past and the SMS reminder system was based on manual entry of the text message. This study's results indicate a significant correlation between SMS reminders and non-attendance supporting the notion that non-attenders were deliberately targeted for SMS reminders. Therefore, the real effect of the SMS text message reminders cannot be determined through this study. A better way to measure the impact of SMS reminders would be to measure attendance before and after universal automatic SMS reminders or compare two groups that is, with and without text message

reminders. The researcher aims to conduct a follow up (post doctorate) research comparing the impact of pre and post text reminders messages system change on clients' attendance as well as between-group comparison (with and without text message reminders). The percentage of households with mobile phones in the UK also increased from 80% in 2010 to 95% in 2017/18 (Statista, 2019). It would be appropriate to assume that majority of the service users now have access to mobile phones. Therefore, the proposed post-doctorate study will compare the data of 2010-2013 (used in this study) with recent data such as 2016-2019.

Gurol-Urganci et al. (2013) published a Cochrane review based on randomised controlled trials assessing text message reminders for healthcare appointments. They reported that the use of text message reminders increased patients' attendance rate. According to Ofcom (2019) smart phone usage increased from 17% in 2008 to 78% in 2018. Muench et al. (2013) proposed a theory driven text messaging intervention for continuing addiction support. They reported that "98% of their participants were potentially interested in using text messaging as a continuing care strategy" (Muench et al., 2013: 315). Milward et al. (2014: 625) conducted a narrative review and suggested that 'multi-component text message intervention incorporating different delivery and content strategies' could be used to improve clients' attendance at substance treatment services. This means that the addiction treatment providers should consider to incorporate text message-based interventions in their service provision. The current COVID-19 pandemic situation has enforced most treatment providers to offer remote service, that is, via phone or video chat applications. The threat of this deadly virus has also created an opportunity for the treatment providers to offer nontraditional modes of delivery of interventions. However, this does raise concerns about training gaps and information technology infrastructure issues, therefore, treatment providers should invest in staff training specifically in delivering remote (phone/online) interventions and required technology.

5.2.6 Time of the appointment

This study highlights a 15:30 to 15:59 time slot increases the likelihood of DNA, whereas clients are more likely to attend their morning appointments (except 11:00-11:29) and after 5:00pm. It can be argued that many clients would be 'too drunk' to attend their

later appointments. It is important to note that the 15:30 – 15:59 time slot is also school pick up time. Therefore, it could be suggested that low attendance could be related to parents being unable to attend due to school runs. On the contrary, parents with children living them were more likely to attend compared to any other group with the highest DNA rate among those who 'refused to answer' and 'pregnant clients'. Out of hours appointments (after 5:00pm) were usually given to clients who worked during the day. In my opinion, being able to retain their employment demonstrated that this client group had not developed severe addiction or associated health issues or that their alcohol problems were yet to result in an inability to do fulfil their paid employment. Out of hours appointments were offered on limited days and therefore often clients had to wait longer for evening slots and strict attendance commitment was expected. It could be argued that practitioners' relatively strict expectations impacted clients' commitment to attend their appointments, as frequent DNAs would have led to losing evening time slots. Clients with additional complex needs such as mental health, chronic health issues, housing issues or safeguarding and wellbeing concerns, were usually given daytime appointments in order to work effectively with multidisciplinary teams or to ensure urgent referrals could be made to partner services. Many such services were not available out of hours with the exception of emergency services. In my view, out of hours appointments were offered to clients who were more committed, somewhat stable, with less additional needs, higher attendance history, and fairly functioning lifestyles, therefore, those clients were more likely to attend their appointments or cancel their appointment instead of not showing up.

Booth and Bennett's (2004) study shows that clients were more likely to attend morning appointments than afternoon appointment at an alcohol clinic. There is a dearth of published research in this area. Very limited addiction, physical, or mental health service-based studies were found during an extensive literature search that focused on the time of appointments and its link with clients' attendance. Poll et al. (2017), in their qualitative study exploring missed appointments with a hepatitis C outreach clinic, made a reference to the 'timing of the appointment' in relation to challenges reported by their participants using public transport. This research study supports Poll et al.'s (2017) further findings, that forgetfulness, competing priorities, client characteristics, costs of travel, difficult journey and timing of the appointment were reported reasons for clients' non-attendance at a

hepatitis C outreach clinic. Cohen et al. (2007) suggest that the timing of the appointment has an impact on adult otolaryngology patients' attendance at scheduled appointments. Their study (Cohen et al. 2007) suggests that patients were more likely to not attend between 2:00 and 4:00pm whereas the lowest non-attendance percentage was between 7:00am and 2:00 and they speculated that this difference could be related to a 'less convenient' time slot (2:00 – 4:00 pm) for patients. Cohen et al. (2007) do not elaborate their phrase 'less convenient' however it could be suggested that this time slot is school pick up time.

5.3 Chapter summary

A secondary analysis was conducted on an existing dataset comprising 194,679 treatment appointments detailing clients' (n=22,405) attendance history for four years (Jan 2010 – Dec 2013). The clinical data were analysed using chi-square and hierarchical four-stage binary logistic regression model to identify factors predicting non-attendance. Clients with the following characteristics were more likely to be recorded as 'did not attend (DNA)'; those aged between 18-24 and 75+ years old compared to other age groups; people on employment support allowance; people who were economically inactive due to mental ill health; those recorded as long-term sick or disabled; people assessed with high risk levels; and young persons in settled accommodation. Clients who live with 'some of their children', had 'none of the children with them' and the clients 'who were not parents' were more likely to not attend compared to clients who have all the children living with them. Two appointment time slots 15.30-15.59pm and 11.00-11.29am increased the likelihood of non-attendance, whereas the 11:30-11:59 time slot reduced non-attendance by 74.5% (comparison group: 9:30-9:59am). Gender, smoking status, pregnancy status, and dual diagnosis did not significantly predict non-attendance.

The above discussion highlighted that addiction services need to address policy and practice gaps in relation to enhance young people and BAME clients' engagement. It appears that the participating agency performed well in relation to clients' attendance rate regarding White British clients and clients with the history of severe addiction issues including physical dependencies. Clients were more likely to develop severe addiction issues and associated health and social issues such as, liver problems, housing and family issues later in their lives. In my opinion, the agency's standard practices and knowledge

bank mainly geared towards clients with above mentioned clients with severe addiction issues compared to clients you had not yet developed serious addiction issues such as, younger clients. It is important that the addiction services develop more young people-focused protocols. Similarly, colour-blind attitude and lack of understanding of impact of racial differences by the agency staff could have contributed to higher DNA rates among BAME client groups compared to White clients. The above discussion highlighted the significant positive impact of family and friends' involvement in clients' treatment on their attendance rates. This research confirms the previous research findings that involving family members including significant others in the clients' treatment positively supports clients' treatment goals and service engagement. It is important that addiction services incorporate family involvement interventions, such as, Social Behaviour and Network Therapy, for all their clients' treatment plans.

Chapter 6 Findings – Practitioners' Views

This chapter sets out to explore the findings of practitioners' perspectives (semi-structured individual interviews). The overall aim of this research was to explore the reasons for non-attendance by clients involved with a community-based alcohol service. The key aims of the practitioners' strand were to explore practitioners' perspectives with regard to their clients' reasons for non-attendance and how their attendance can be improved. This strand set out to address the following research questions: What are the main reasons for clients' non-attendance at appointments within a community-based alcohol service in practitioners' views? How do practitioners experience their clients' non-attendance – exploring their (practitioners') thoughts, feelings, interpretations and behaviours? What do practitioners think will improve their clients' attendance?

6.1 Practitioners' perspectives – individual interviews

This section presents the findings of individual interviews with practitioners exploring their experiences of clients' non-attendance. Template analysis (King, 2012) was used to analyse practitioners' interviews (see Chapter 4). Four main themes incorporating 14 sub-themes were identified from this analysis. The four main themes were:

1. Reasons for non-attendance
2. 'Magic Spark' – Co-created motivation to attend
3. DNA[8]: a system's need
4. What needs to happen: 'Change of paradigm'

6.2 Sample profile

The following Table 6.1 shows participants' (practitioners) demographic information. A total of 15 practitioners participated in this study; twelve females and three males; thirteen White British and two British Asian; six participants between 25-34 years age-range, four between 35-44, four between 45-54, and one between 55-54. Work experience in the

[8] DNA = Did Not Attend

addictions field varied from two to 29 years. In terms of their roles, four worked as support workers, four as practitioners, five as senior practitioners, and there was one manager and one senior manager.

Table 6.1 Participants' (Practitioners) demographics

No	Name (pseudonym)	Age	Gender	Ethnicity	Current Role	Experience in years
1	Ken	45-54	M	White-British	Support worker	2
2	Jemma	25-34	F	Asian/Asian British – Indian	Practitioner	6
3	Ruth	35-44	F	White - British	Manager	15
4	Kim	45-54	F	White - British	Senior practitioner	15
5	Kate	25-34	F	White - British	Senior practitioner	7
6	Dave	35-44	M	White - British	Support worker	11
7	Anne	45-54	F	White - British	Practitioner	17
8	Beth	25-34	F	White - British	Support worker	4
9	Emily	25-34	F	White - British	Senior practitioner	9
10	Leyla	25-34	F	Asian/Asian British – Bangladeshi	Practitioner	13
11	Heidi	25-34	F	White - British	Support worker	2
12	Sarah	35-44	F	White - British	Practitioner	13
13	Carmen	35-44	F	White - British	Senior practitioner	11
14	Rob	45-54	M	White - British	Senior manager	25
15	Laura	55-64	F	White - British	Senior practitioner	29

Table 6.2 (below) shows the main themes and sub-themes identified in this research in relation to practitioners' perspectives.

Table 6.2 Template analysis: main themes and themes template

Reasons for non-attendance ⟷

- Clients' characteristics
- Patterns linked with DNA
- Client reported reasons for DNA
- Service-related factors

Research question

What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service in practitioners' views?

'Magic spark': Co-created motivation to attend ⟷

- Motivation wavers
- Co-created motivation to work together

DNA: a system's need ⟷

- Feeling relieved when clients DNA
- 'There is always something else to do'

Research question

How do practitioners experience their clients' non-attendance – exploring their (practitioners) thoughts, feelings, interpretations and behaviours?

6.3.4 What needs to happen: 'Change of paradigm' ⟷

- Creative engagement
- Offering a flexible service
- Proactive follow up

Research question

What do practitioners think will improve their clients' attendance?'

There are three levels of themes presented. The main-themes will be presented in **bold**, themes with <u>underline</u> and sub-themes in *italics*. The findings will be presented followed by a brief discussion or comment. Full discussion of the findings will take place in chapter 8.

6.3.1 Reasons for non-attendance

This theme covers four sub-themes; i) client's characteristics, ii) patterns linked with DNA, iii) client reported reasons for their DNA, and iv) service-related factors linked with clients' non-attendance at a community-based alcohol service.

Participants reported a range of client characteristics and patterns linked with their non-attendance. This theme addresses one of the key research questions, that is, which clients were more likely to not attend their appointments. It also covers factors relating to service delivery linked with clients' non-attendance.

<u>6.3.1.1 Clients' characteristics</u>

Several participants highlighted that certain clients are more likely to DNA such as younger clients (18-24), ethnic minority clients and clients with complex needs. Age, ethnicity and multiple needs were identified by many participants as factors associated with clients' DNA history.

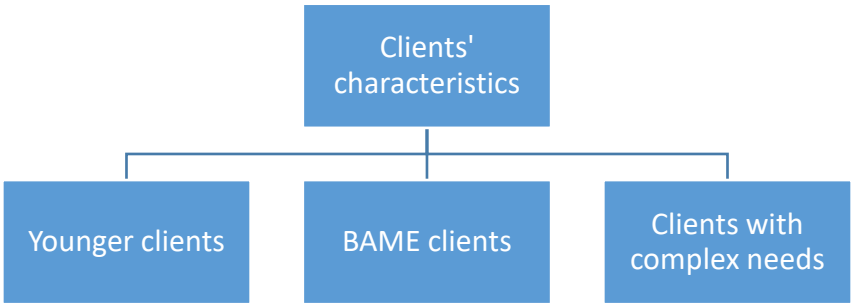


Figure 6.1: Clients' characteristics: sub-themes

Young People (18-24 years)

Eleven participants identified a common theme relating to a lack of acceptance among young people about their drinking/drug problems. Experimenting with alcohol/drugs, lack of organisational skills (required to attend an appointment), a care-free attitude and impulsivity (deciding to not attend their session at the last minute) were some of the issues highlighted in relation to young people. Heidi, Rob and Kate highlighted the issues of non-attendance among younger clients (18-24):

> *"…I think definitely with the 18 to 24, we've had a few people being referred and they're just so hard to get hold of. You'll talk to them once and then they'll just DNA each assessment you book for them." (Heidi)*

> *"…I think it's a big thing for them [young people] to take on a view that they have a problem with alcohol and drugs when probably their view of, seeing as they're either experimenting or social users, the idea that they may have a problem is hard to take on board." (Rob)*

Kate highlights a range of factors in relation to higher DNA rates among young people:

> *"I think in young people they don't have necessarily the long sight that adults have, they can't necessarily see the immediate benefits of attending appointments, disorganisation sometimes with young people, having better things to do, not having the funds to get to an appointment, not having always a structure or routine in their lives, just because that's the nature of being young that you're more spontaneous maybe." (Kate)*

It is interesting to note that peer pressure to use alcohol/drugs was not identified by any participant as a reason for non-attendance in spite of it being a commonly reported

reason for many young people to engage with substance misuse (McKay et al., 2012). In my view, peer pressure may be linked with using alcohol/drugs but may not be seen as an important factor in relation to attending substance use treatment appointments. The next section presents findings relating to ethnicity and non-attendance.

Ethnicity

This qualitative strand supported the results of the quantitative strand that ethnic minority clients are more likely to DNA. Participants in this study highlighted issues like taboo, stigma, distrust, history of discrimination in the mental health field and religion as contributing factors for BAME (Black Asian and Minority Ethnic) clients to not attend:

> *"For ethnic minorities, its issues around stigma, taboo, perhaps there's issues being seeing going into an agency such as this, or being known that you've got a problem that you need to access this service for, this would prevent some people from coming." (Jemma)*

Jemma and Heidi talked specifically about South Asian communities:

> *"…particularly in South Asian Communities, there's a lot of taboo around having substance misuse problems to begin with, so there could be denial and non-acceptance over the fact that I have an issue." (Jemma)*

> *"…It's a taboo because in the South Asian community many religions, like Islam, Sikhism, it's actually forbidden to consume alcohol as an intoxicant." (Heidi)*

Religious expectations and strict rules about ways of living, on one hand can support healthy lifestyle such as complete abstinence (such as in Islam and Sikhism), but they can also

impact a person's capacity to access and engage with available support. This is because a Muslim client may find it very difficult to accept that they have a drinking problem and to seek support given their drinking is strictly forbidden in Islam (Qur'an 2:219). The sense of committing a sin possibly leads to denial both at intrapersonal and at a collective level within a community. Jemma further speaks about the specific issues in relation to the Sikh community:

> *"…there's a massive problem within the Sikh community of alcohol misuse, but when you come down to what the scriptures of Sikhism say you're prohibited to drink or use it as an intoxicant but that's not generally followed apart from blanket statements but for a lot of the population it's not really followed, so there's a conflict between what the religion is saying and what the cultural practice is, and although it's seen and everyone kind of knows that everyone does it, but it's discussed in a context of we shouldn't actually be doing this, the conversation almost changes, we don't wish to be doing it so we won't say we've got a problem with it because we're not supposed to be doing it in the first place…" (Jemma)*

Rob highlighted a dilemma regarding confidentiality and language barriers. There are over 20 different languages spoken in the West Midlands. According to the 2011 census about 7% population in the West Midlands spoke a language other than English (migration-observatory, 2018):

> *"It's a two way thing really for me to say we have people there from the community that speak appropriate languages but at the same time you've got the issue of people worrying about other members of the community finding out they have a drink or drug problem and not trusting that it will be kept confidential within the community."(Rob)*

Jemma reported how families could also encourage clients to not attend. The issues of

shame and family honour impacted the clients' attendance at addiction services. Women's substance use, in general, was considered to be 'source of shame and honour' in some cultures making it even more difficult for many women to seek support for their addiction issues:

> *"… female clients in particular don't want to get help because there's even more of a stigma associated with their drinking. Particularly in Asian families there's a wider dialogue about society and the community knowing or someone having an alcohol or substance misuse problem in the family and the shame that comes along with that so families can cover that up and persuade people not to attend appointments, and that they are there for support and they don't need external support." (Jemma)*

Rob specifically explored issues relating to Black clients and inherent mistrust:

> *"...we have historically had challenges in terms of making the service accessible to a variety of ethnic minority communities… And for me in terms of the Black communities, traditional distrust of mental health services…. We are associated with those social services so it's kind of fear and mistrust of us that we haven't managed to break down." (Rob)*

Ethnicity was just one factor among others that practitioners highlighted regarding client's non-attendance. Participants discussed about complex interrelated factors that impact BAME clients, such as, specific differences within BAME clients (Muslims and Sikhs), unique challenges of certain groups (Black clients) and different implications for female clients. Practitioners suggested that stigma, family honour and shame contribute to BAME clients' denial of personal addiction issues and therefore, not seeking or attending treatment. The issue of family honour particularly impacted BAME female clients because families discouraged them to reach out for support. The next section presents findings relating to complex needs.

Complex Needs

The term complex-needs refer to clients with additional needs. The participating agency's database defined this term as clients with severe mental health issues, issues of domestic abuse, safeguarding issues, serious physical health issues, serious offending history, serious housing problems, history of significant self-harm and history of consistent suicidal thoughts or/and attempts and chronic addiction issues.

Jemma highlighted an interesting phenomenon - fear of change - in relation to clients with multiple needs;

> *"High risk is [clients have] chaotic lifestyles, still actively engaging in substance misuse, forgetting appointments, not ready to change, ticking boxes off for organisations to say 'I am coming' but they're really not. A big one is fear of change, particularly [among] a high risk group, or perhaps you're unemployed [and] that's what you've known for a long period of time, you're unsure of yourself, what you would do next, unsure what you'd be without that lifestyle [without drinking]." (Jemma)*

Kim identified complex health issues such as Wernicke's Encephalopathy (W.E.) and mobility issues as reasons for non-attendance. The British Medical Journal defines W.E. as 'a neurological emergency resulting from thiamine deficiency with varied neurocognitive manifestations, typically involving mental status changes and gait and oculomotor dysfunction' (BMJ Best Practice, n.d.):

> *"We worked with a lot of clients with different cognitive abilities so we have people with dementia or early onset of Alzheimer's or Wernicke and a lot of their DNA was solely because they'd forgotten and there was a lot more pressing health issues and a lot of mobility issues so I would say that's the highest rate of DNA that we've had in a project even compared with youth projects before." (Kim)*

Emily talked about competing needs such as domestic abuse support and housing for complex needs clients which directly impacted their capacity to attend their appointments at an alcohol agency:

> *"…they're aware that they need to make changes, they're aware of their substance misuse and the impact it's having but it's very low down on their agenda to address at the moment purely for the external factors that are kicking in at the moment. So domestic violence is a big one for one of the clients. And it's sorting out housing before I can even think about sorting out substance misuse…" (Emily)*

This sub-theme addressed a range of clients' characteristics reported by practitioners. Practitioners reported that younger clients, BAME clients and clients with complex additional needs were more likely to not attend their sessions. This has been highlighted in other research that explored client-related factors and treatment engagement. Booth and Bennett (2004) reported younger age associated with non-attendance at an initial appointment at a specialist alcohol treatment clinic in the UK. King and Canada (2004) reported that ethnic minority clients were more likely to not attend substance misuse clinic. Chapter 8 (Discussion) will explore these findings in relation to previous research literature and address how to improve clients' attendance in detail. These findings offer insight into practitioners' perceptions about what kind of clients were more likely to not attend at their appointments. The next section explores findings relating to clients' patterns linked with non-attendance.

6.3.1.2 Client-related patterns linked with DNA

Many participants highlighted certain patterns linked with clients' non-attendance such as stages of recovery, festive periods and seasonal changes. Both early and late stages of recovery are linked with non-attendance though for different reasons. Rob and Anne identified higher DNA rates during early stages of recovery. The terms recovery and

treatment engagement were used synonymously here by practitioners. While 'in recovery' and 'in treatment' can be two different notions; being in recovery does not necessarily require attending a service as clients can effectively engage in changing their own addictive behaviour without any formal treatment. In this context where the participating agency only captures clients' progress during treatment, 'in recovery' in this context means 'in treatment'. References such as early or later stages of recovery also meant early or later stages of treatment engagement in this context;

> *"… the early stages in particular when somebody either doesn't think they can change or doesn't believe they have a problem or [are] contemplative or pre contemplative they're much more likely to not attend." (Rob)*

> *"I would say it's higher for people first coming into service, when they start coming into service you see somebody regularly, DNAs would fall then but initially it seems to me it's quite hard to get people to come"' (Anne)*

On the contrary, some participants suggested that the DNA was higher towards the tail end of the service engagement. Jemma linked complacency with later stages of recovery:

> *"Yeah certainly you get more DNAs - at the tail end of recovery because they're kind of moving on with their life and things come up and it's like I'm sorted now I don't really need to go to that appointment." (Dave)*

> *"On the other hand there could be issues of complacency later on in the treatment journey, so a client could feel they have learnt enough, done enough work, looked at themselves and now they can take it on themselves and they might not engage." (Jemma)*

Heidi and Sarah explored issues of seasonal changes and festive periods in relation to clients' attendance. Where Heidi considered that in summer her clients' non-attendance

rate is usually higher, she also linked it with school holidays and clients with children may find it difficult to arrange a suitable childcare in order to attend their appointments:

> *"I would say to me, coming up for like summer… they're like oh summer, you know. If it's nice weather, I was sitting in beer garden or the pub with my friends. So during the summer I feel we're quite, quite to an extent just because I feel a lot of people, especially if they've got children, you know school holidays, but a lot of the time I imagine they're a lot of people going it is nice weather and then imagining cold beer in the sun in the beer garden." (Heidi)*

Sarah and Heidi also highlighted that there were usually higher DNA rates during Christmas time:

> *"… Over Christmas obviously, Christmas and new year because everybody's drinking obviously, people drink a lot over Christmas and new year and I think it's just, and then you've got service is closed certain times…" (Sarah)*

> *"… a lot of people don't wanna change their behaviour when they've got a Christmas party, Christmas generally, people tend to drink more and they don't want to miss that and also I can imagine it would be harder to for some people to stop and then try maintaining abstinence over a period where they've been invited to parties here and there..." (Heidi)*

This theme explored certain patterns linked with clients' non-attendance. In practitioners' views, clients are more like to not attend their sessions during early and late stages of recovery, summer and festive periods. The next section presents what practitioners said were client reported reasons for their non-attendance.

Thirteen out of 15 participants reported that 'forgetting the appointment' as the most commonly reported reason by clients for their non-attendance:

"… normally [they] just say they've forgotten." (Beth)

"… It used to be that they forgot, so it'd be that they forgot their appointment time … One of the common reasons was 'I completely forgot I thought it was next week'." (Carmen)

"Most of the time they say they forget." (Heidi)

The above quotes highlight the need for appointment reminder interventions such as text message reminders. This highlights a gap in service, that is, an effective appointment reminder system, for example, using an automated text message system or phone calls to remind clients a day before their appointments and on the day of their appointments. Gurol-Urganci et al. (2013) reported that the use of text message reminders increased patients' attendance rate in their Cochrane review based on randomised controlled trials assessing text message reminders for healthcare appointments. They. Later, I will discuss (Chapter 8) in detail the evidence for effectiveness of using text message reminders. Several participants identified other reasons reported by their clients for their non-attendance such as; health, other commitments (such as other appointments), travelling, not being organised, overslept and feeling low. In the next section, I will explore service-related factors in relation to clients' non-attendance.

6.3.1.3 Service-related factors

This theme (service-related factors) further divided into four sub-themes in order to capture participants' reported service-related factors (Figure 6.2): waiting times, building, location of the service and funding cuts.

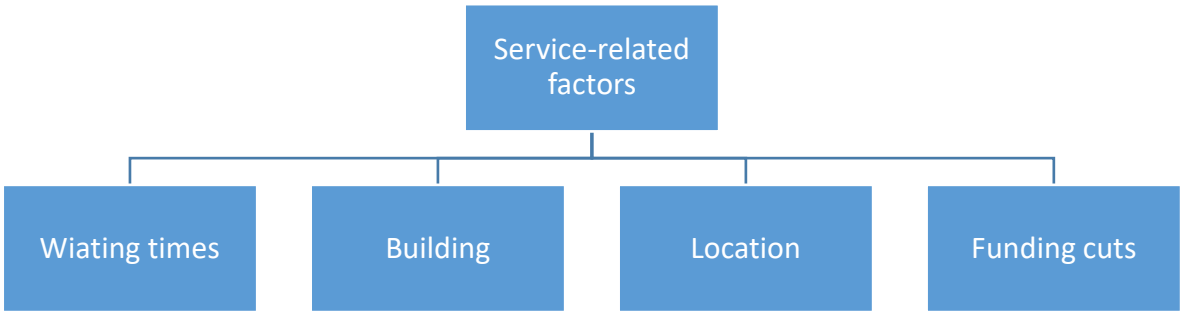


Figure 6.2: Service-related factors: sub-themes

Waiting times

Eight participants (Anne, Beth, Dave, Emily, Kim, Kate, Sarah, and Laura) stated that 'waiting times' was the most impactful service-related factor regarding clients' non-attendance. Several participants highlighted specific issues related to the client allocation process. Clients were seen for their initial assessment meeting promptly but then in some cases clients had to wait for several weeks in order to be allocated a practitioner. Anne suggested that, due to a long waiting time between the assessment session and the first meeting, many clients did not turn up for their first meeting having had their assessment attended a few weeks ago:

> *"… although they assess quite quickly there might be a gap between [assessment and] allocation, they're still waiting for appointments, I've just noticed when I'm given allocations, there's not many I'm having any contact with." (Anne)*

> *"…and they've taken a step to self-refer or they've taken advice from the GP and they've referred over the phone, they've had the triage completed and then it's a long time waiting for their [first] appointment." (Emily)*

> *"… waiting times are a pain, they are obstructive in terms of engaging with somebody." (Laura)*

Long waiting times for first sessions negatively impact clients' non-attendance. Participants suggested that long waiting times between initial contact and assessment sessions and then between an assessment session and the first meeting negatively impact clients' attendance rates particularly at early stages of their treatment. Practitioners also highlighted above (6.3.1.2) that clients are more likely to DNA at early stages of their treatment and therefore long waiting times between referral and assessment sessions and then between assessment sessions and first meeting with an allocated practitioner would further contribute to clients' low attendance rates at initial stages of their treatment. Stasiewicz and Stalker (1999) reported that shorter waiting times between the initial referral and the first meeting results in higher attendance rates at substance misuse services. The next sub-themes explore the issues related to location and anonymity of the service building.

Building – location, privacy and accessibility

Many participants highlighted the significance of the building in relation to its location, environment and anonymity. Travelling distance, public transport access, welcoming environment and somewhat discreet building location and presence are important issues which impacted clients' attendance. Leyla highlighted the importance of discreet service presence to help clients' sense of being seen walking into an addiction service and taboo attached to it:

> *"… it's having a space that isn't specifically addiction services that's the main thing…. A lot of people have mentioned that to me that I was really concerned about coming in and when I came in and sat in reception I was really, felt like I was in just another office, which is good." (Leyla)*

Kate shared about the importance of confidentiality and privacy in relation to building/space and service. Fear of lack of privacy and possible breach of confidentiality negatively impact clients' engagement:

"The environment of the offered place needs to be thought about, is it going to be confidential? Am I going to see someone I know, are you going to tell somebody that I'm in your service explaining how the confidentiality works, it's always who're you going to tell about this, making it clear from the start…" (Kate)

Beth talked about her service site which was located within a public building (local library) and her clients found it more comfortable coming in as their entrance into the building could not be linked with attending an addiction service:

"... it's like a public building, it's not got alcohol or addiction everywhere, nobody knows what they're coming for…." (Beth)

Service location is also an important factor specifically in relation to travelling options and distance. Many clients relied on public transport for their attendance, a service location within a single bus ride is an important factor:

"... it's really important that clients feel they can easily get to a location." (Beth)

"... it's a huge impact, when we were in the outreach teams we made sure each of our bases were only a bus ride away from the postcode areas that we were funded to cover and that had a massive impact on attendance rates." (Kim)

Ruth specifically highlighted the importance of 'outreach' service provision:

"... The whole thing I've struggled with is location where we bring everybody in to the service to be seen where I'm very much outreaching to the community in various locations so people come and see us there because people are more likely to come and see you at the community rather than in a building located in the centre of town." (Ruth)

Kim and Anne also supported the idea of outreach service provision highlighting 'travelling' as one of main reasons for clients who did not attend:

> *"… I think it does have an impact, more recently, there's less outreach work and it's more at the core [office] and that creates problems….. some of them for a variety of reasons wouldn't actually come to core [office] so that would put a barrier in there…" (Anne)*

> *"... If we were just static, it's a long way working the rest of (name of the town) and you've got to have a lot of motivation and if you're working with people with withdrawals and the letter says you can't drink on that date, you're not going to attend, it's difficult." (Kim)*

Emily highlighted specific issues related to service venue linked with ageing population and lack of appropriate funding for more satellite venues:

> *"… with more time and more funding we would like more venues again in harder to reach places so we have just started a support group over in K**** [town name] because we know that's a hard to reach area and client type as well so we are trying to push out to local areas. There are rural parts of S**** [town name] that are very hard to tackle to be fair so yes location is crucial." (Emily)*

The location of the service site, travelling distance and anonymity of the building were highlighted as important factors that impact clients' attendance. Previous research also reported that longer travelling distance and location of the service site associated with clients' higher non-attendance (Booth and Bennett, 2004; Jackson et al., 2006). Therapeutic environment is an important factor in enhancing clients' engagement as it supports the process of therapeutic containment and connection in the therapy room. (Morrey et al.,

2020). For clients, a welcoming, relaxed and homely environment is linked to feeling safe and comfortable in the counselling room and therapeutic encounter (Sanders and Lehman, 2019). The next sub-theme presents findings relating to funding issues.

Funding cuts

It was not surprising that participants shared that clients' engagement and attendance was directly affected by the funding issues. Many participants highlighted issues related to lack of necessary funding and the impact on clients' attendance at the agency. Funding cuts directly and negatively impacted the effectiveness and efficiency of the service delivery such as; staffing issues, continuity of support, diverse workforce, evening or weekend service delivery provision, waiting times and venues.

Several participants linked funding cuts with staff shortage, waiting times, service cancellations, effectiveness of service delivery, higher caseloads, lack of outreach service provision, and focus on performance targets output instead of client-centred outcomes. All these issues were associated with clients' engagement and attendance history. Dave talked about the impact of service cancellation due to funding cuts which then led to clients' non-attendance. Kate highlighted risk of staff burnout due to funding cuts impacting their ability to engage with their clients effectively. It also limited the extent of support that could have been offered to clients. Limited funding meant limited support. Figure 6.3 shows the ways in which lack of funding negatively impacted the service delivery and clients' engagement.

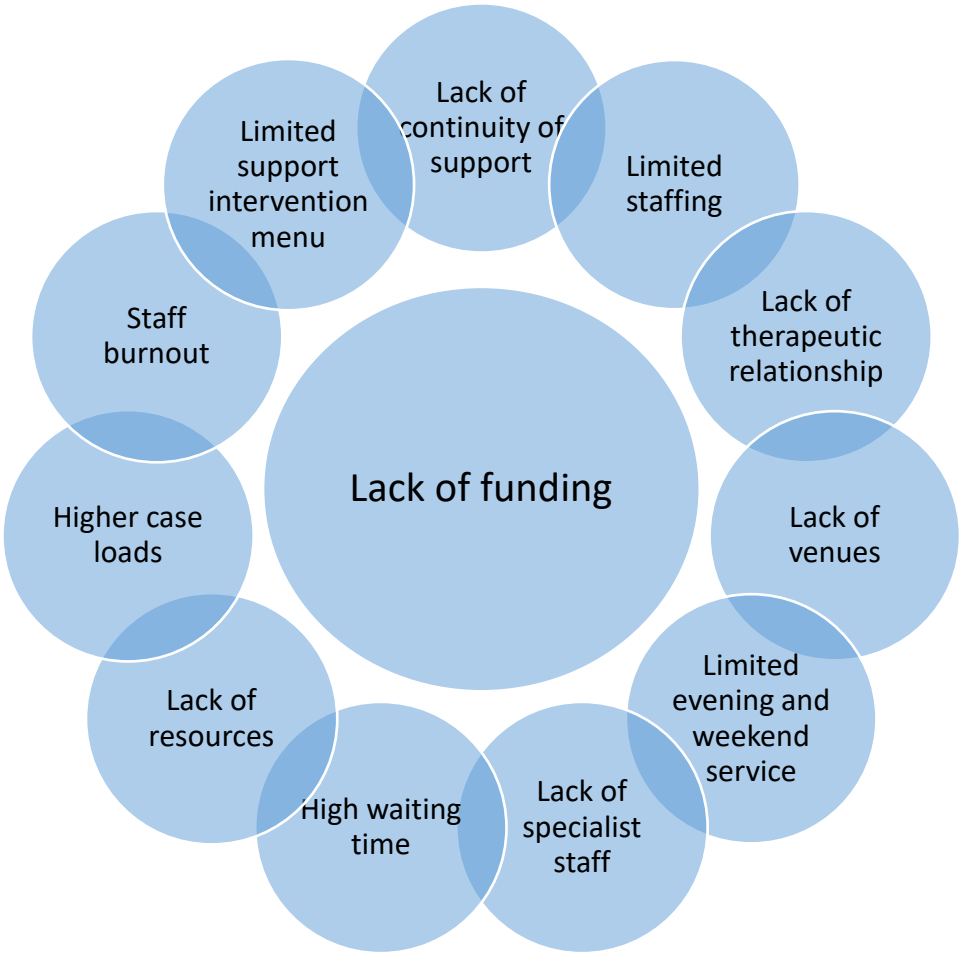


Figure 6.3: Impact of funding cuts

Dave, Kate and Kim highlighted a range of issues linked with funding cuts and how this impacts clients' attendance:

> *"... if there are funding cuts and they're short of staff, the building locations aren't available as much……. you cancel once, then they stop coming…" (Dave)*

> *"... It affects everything. It impacts how much staff you've got, that impacts your waiting times. Funding cuts doesn't stop people coming into service, still have this service to provide but it's not as effective if you have less staff who have higher caseloads, who don't have as much time to offer, get burnt out more quickly…" (Kate)*

"… think funding cuts as well, because you can't offer them a menu of options, which is something that really does engage people…… with the funding cuts not being able to offer that, substance misuse [treatment] can't be a one size fits all, never has been, never will work that way." (Kim)

Jemma identified the impact of staff change due to funding cuts on client-practitioner relationship leading to clients' non-attendance.

"I think it's a big factor because we might engage clients into the treatment journey but when we can't provide the worker and we have to refer them onwards, it's quite frustrating because the client has engaged with you and motivated themselves and now they might feel they are being pushed back and forth……. And with funding cuts we've experienced recently with the loss of a project……will they have a rapport with their new worker so it can bring up a lot of uncertainties for them and particularly if it can lead them to relapse which is a hard thing really." (Jemma)

Many participants shared their concerns about lack of funding and staffing issues such as not having enough staff, lack of specialist staff (such as bilingual), lack of male staff, and lack of experienced and competent staff.

"Funding is most definitely a big factor. I think we would like a lot more practitioners with a decreased caseload that would have more time for one to one client work rather than paperwork, getting it and putting it on the electronic system, reaching stats for KPIs …." (Emily)

Emily also shared her concerns about the focus on key performance indicators (KPIs) set by the service commissioners. She talked about the shift of focus from a client-centred to a commissioner-centred service approach and it negatively impacted on clients' attendance:

"… a lot of the funding and the tenders that are coming at the moment, their budgets are getting squeezed and squeezed so that the opportunity to have specialist outreach roles becomes less ..." (Ruth)

"… there are funding cuts and they're short of staff, the building locations aren't available as much, you might be going to a group because such and such staff members are off, a whole layer, not enough staff to cover if the groups cancelled, you cancel once then they stop coming." (Dave)

Beth discussed about the longer waiting times due to lack of resources and staffing. Waiting times impacted clients' motivation to engage with a service and their attendance rate.

"… they can have their first appointment but to be allocated to see a worker they might be waiting a while because there's not enough staff to deal with the demand of clients so if you've had an appointment and then you're waiting three weeks to be allocated and your worker to have a slot because they've got too many people on their caseload that is going to impact." (Beth)

Kate and Kim highlighted a range of issues linked with funding cuts such as staff burnout, compromised service provision, limited menu of options (types of support interventions available) and long waiting times. Laura talked about the negative impact of extensive paperwork and administrative tasks in addition to her clinical work and consequently adversely impacting her capacity to offer an effective therapeutic relationship to her clients.

"… It (funding cuts) affects everything. It impacts how much staff you've got, that impacts your waiting times. Funding cuts doesn't stop people coming into service, still have this service to provide but it's not as effective if you have less staff who have

higher caseloads, who don't have as much time to offer, get burnt out more quickly, are constantly having to think of creative ways of working, where am I going to see you, how am I going to do this, how can I have ever shrinking resources, it's massive." (Kate)

"… [I] think funding cuts as well, because you can't offer them a menu of options, which is something that really does engage people, we had a fishing group, art group, coffee, chat, knitting group……. if you listen to them then your DNA rates are low because you're engaging people the way they would like to be engaged and then you can slip your message in. Like around a cup of coffee or some acupuncture or whatever but I think with the funding cuts not being able to offer that, substance misuse can't be a one size fits all, never has been, never will work that way." (Kim)

This sub-theme captured a range of service-related factors identified by practitioners in relation to clients' non-attendance. Lack of appropriate funding adversely impacts the service delivery at all levels including clients' engagement and attendance. Roy and Buchanan (2016) highlighted that the current period of financial austerity has negatively impacted a wide range of services including substance misuse treatment provision. The next theme considers individual practitioner-client relationship factors and introduces the novel concept of co-created motivation.

6.3.2 'Magic spark': co-created motivation to attend

The concept of motivation for change (stop drinking) underpins the treatment approach at the participating agency so it is perhaps unsurprising that practitioners talked about the notion of motivation extensively in their interviews. The key concept of motivation underpinned their reflections on clients' attendance at their appointments. Participants talked about the role of motivation in a client's drinking and engagement with support services. This main theme is further divided into three themes (Figure 6.4); 'motivation wavers', 'staff motivation', and 'magic spark'.

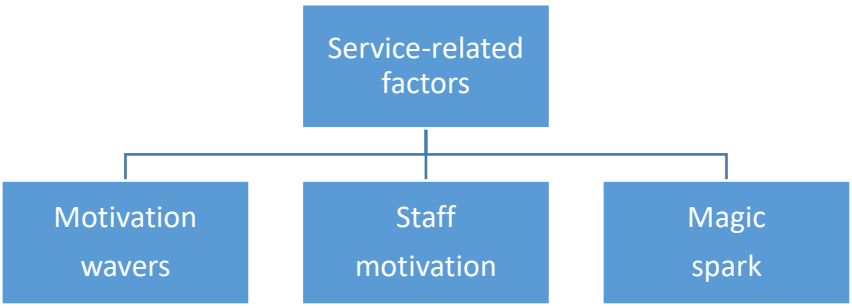


Figure 6.4: 'Magic spark: co-created motivation to attend': sub-themes

6.3.2.1 Motivation wavers

Motivation to drink, motivation to stop drinking, as well as motivation to attend appointments, fluctuates. It changes depending on a range of interlinked factors directly impacting a client's drinking behaviour. Many participants highlighted the wavering aspect of their clients' motivation and how it impacts clients' engagement and attendance at the agency.

Some participants explored motivation in relation to the 'stages of change' model (Prochaska and DiClemente, 1983). They presented a six-stage model of behaviour change that is, pre-contemplation, contemplation, preparation, action, maintenance, relapse (Prochaska and DiClemente, 1983):

> *"I think motivation and momentum wavers it goes up and down and kind of cycles." (Rob)*

> *"It's so pinned on someone's motivation, so I used to see somebody who would come to the service, full of every intention and hope and motivation to change and then the next week it would be a completely different person." (Kate)*

> *"... we've had people that come in for assessments and in that moment they're really up to making changes, they've been introduced to the service but then have so many DNAs." (Emily)*

Participants identified a number of factors that had an impact on people's motivation to attend; such as finances and complacency. Kate identified access to money as a factor linked to change of motivation:

> *"… I realised it tied in with when he was paid so worked out you need more motivation when you have money, to stop or to want to stop…" (Kate)*

Laura linked complacency with relapse and non-attendance:

> *"… people get a bit well actually I'm in control here and then they come back three weeks later because they've had a relapse so that does happen sometimes that people get a little bit complacent, think they've cracked it." (Laura)*

Several participants discussed about the role of motivation in clients' desires to change their drinking habits. They highlighted that motivation to drink or to stop drinking is not a constant phenomenon. Instead, it changes. Ball et al. (2006) reported that motivational inconsistencies negatively impacted clients' engagement at an addiction treatment service. Coulson et al. (2009) concurred with Bell et al. (2006) and stated that motivational ambivalence adversely influenced clients' engagement at an alcohol and drug service.

In practitioners' views, a number of factors impact clients' motivation such as access to cash to buy more alcohol, feeling complacent, support available, and relapses. The next theme focuses on the staff motivation to work with and be available to their clients.

6.3.2.2 Staff motivation

Ten participants highlighted the significance of staff motivation in order to effectively work with their clients. There were a number of interrelated factors that impacted practitioners' motivation such as burnout, extensive paperwork, funding cuts, quality of clinical supervision and believing that change is possible.

Rob emphasised the role of management or leadership to ensure their staff felt motivated to work. Committed and passionate leadership was essential to create an environment within an organisation to make a difference as highlighted by Rob:

> *"I think … motivating [the] workforce… [depends on effective] leadership or management. Do managers really believe, do they believe in what we're doing and, I know it sounds strange, but if they don't believe and they don't get it and they're not passionate about it then they're not going to be able to enthuse the staff about making a difference." (Rob)*

> *"If you've managed to engage with the client because they actually want to be helped but you're being perceived by the client as someone who's not interested in their work or very busy or is cancelling appointments because you're trying to juggle too much, that's a massive factor." (Jemma)*

Carmen, Ruth and Jemma suggested practitioners' motivation and willingness to work with their clients impacted upon their working alliance and clients' future attendance at the agency:

> *"At the end of the day if a service user is coming to you bearing their soul, so they're telling you a lot of things that have happened in their life that have contributed to addiction, so if you haven't got that rapport, as a service user you could be thinking, I don't really wanna talk to this person so I definitely think it does have some impact." (Carmen)*

> *"… if the practitioner showed a high level of motivation to work with somebody, really thoroughly engaged with them in their journey, then you wouldn't be getting*

DNAs." (Jemma)

Participants highlighted that practitioners' motivation to work with their clients and their willingness to be fully present in the counselling room was crucial to clients' engagement and attendance. Kim explored the usefulness of 'understanding your clients' in reducing the DNA rate:

> *"… if you can form that first bit of motivation or understanding with that client, DNA rates [are] minimal." (Kim).*

Heidi further explored the notion of practitioner-client interlinked relational dynamics:

> *"… I would say I think practitioners will be more motivated if they (clients) were more motivated themselves. …... If you've got someone who's coming in, just coming along because an appointment's been booked and they don't want to make any changes, I can imagine that is really demotivat[ing] to the practitioner themselves..." (Heidi)*

Heidi and Kate explored the issue of clients 'being sent' to the service, who were not willing or ready to address their drinking. Often such clients were sent by a third party such as police, GP, family member, social services, courts or employers. She shared that clients might initially accept the referral but, subsequently, did not engage with the service:

> *"… They'll agree to it but then they will actually go… well actually I drink …[a lot]. I enjoy my drinking, um, I don't want that to change and some people will say well drinking is the only outlet I have, If I don't have that I stay at home or I've got no friends, drinking's my only outlet, I don't want that taken away from me..." (Heidi)*

"… So yeah not ready to change, I've been instructed to go by somebody else, if you don't do this I'm going to chuck you out, leave you, so they're paying lip service by going to the appointments…" (Kate)

The above sub-theme addressed the theme of practitioners' motivation to work and support their client. The practitioners' motivation to work with their clients fluctuates depending on a range of factors such as workload, output-based targets, funding cuts, lack of resources, and perceived lack of clients' commitment to engage with the service experienced as clients' non-attendance and relapses. Previous studies in the wider context such as social care, counselling, psychologists and mental health show that researchers and theoretical authors explore the concept of compassion fatigue, burnout and vicarious traumatisation, and that these impact practitioners' emotional wellbeing and motivation to work (Jenkins and Baird, 2002). In the next section, I will discuss about the concept of co-created motivation.

6.3.2.3 Magic spark

As highlighted above, several participants identified the motivation of clients to attend their sessions. They also identified practitioners' motivation as an important factor in the practitioner-client relationship. It was apparent that both the client's and practitioner's motivations mutually impact their work together.

Heidi explored the notion of co-created motivation as something "hard to put a finger on what that is". She refers to it as a 'magic spark' between a client and practitioner. Other participants also explored the similar notion where both the client's and practitioner's motivations were named:

"… so sometimes there's that magic spark and sometimes it's hard to put a finger on what that is, but I think a good, yeah, a good rapport with, between a client and practitioner is important..." (Heidi)

Exploring this 'magic spark' further and who it stemmed from, Heidi commented:

Interviewer: *"Magic spark…. who does it belong to?"*

Heidi: *"I would say it's both. They've got to work towards it together so I would say it's definitely both, it can't be one …… it's gotta be both because the clients got their one-on-one work with the practitioner whereas the practitioner wants to get the best out of them and they've got to want to work with them as well..."*

Sarah and Rob highlighted the importance of 'meeting in the middle', in other words 'supporting a client enough that they feel empowered to support themselves'.

> *"… it is about understanding the client, and somewhere in the middle, you meet with what they're bringing and what you can bring and deliver." (Rob)*

Rob offered further clarity about meeting the client in the middle that it does not mean to be rigid and too prescriptive about the 'middle point'. He suggested that clients need more support at initial stages of their treatment as well as during times when lacking motivation to stay sober. He stated that during such times it is essentially a practitioners' task to support their clients: *"… you have to carry the motivation for the person in the beginning" (Rob)*

The above theme explored the impact of clients and practitioners' motivation to work together and consequently on clients' attendance. Existing research and literature mainly associate the concept of motivation as an individual's issue such as clients' motivation (West and Brown, 2013) to drink, change behaviour and attend treatment sessions and

practitioners' motivation impacted by 'personal' experiences of compassion fatigue (Sprang et al., 2007). This study introduced a novel term 'co-created motivated' to conceptualise relational dimensions of practitioner-client interactions. The concept of co-created motivation is not identified in the exiting literature and adds originality to the existing research and literature on motivation. Co-created motivation refers to interacting forces between a practitioner and client in a counselling room. Practitioners and clients proactively impact each other and impacted by each other (Wollants, 2012). The next theme explores the issue of constantly increasing staff workload and how the clients' non-attendance actually supports staff to complete their routine tasks.

6.3.3 DNA: a system's need

This theme comprises two further sub-themes; 'feeling relieved when clients DNA' and 'there is always something else to do'. The findings of practitioners' interviews highlighted that without a sufficient percentage of DNAs it was not possible for this agency to deliver a service.

6.3.3.1 Feeling relieved when clients DNA

All 15 participants reported feeling 'relieved' at times when their clients DNA, particularly as it allowed them to complete other tasks Individual reasons varied from 'not looking forward to seeing a particular difficult client' to 'so many other things such as entering data and writing notes needed to be done':

> *"… it [DNA] gives you time to catch up on things that are on the 'to do' list that you never get round to doing. So I have had that relief element…" (Emily)*

> *"… sometimes to be honest if it's back to back and you have so much paperwork to do, you have entries to do yes it's nice to get that hour to get stuff done. It's a relief to get some time brought back." (Kim)*

Participants reported that DNAs offered them much needed additional time to catch up with their administrative tasks during very busy day routines. Rob suggested that it was a conscious and unconscious need of practitioners to have a certain number of DNAs in order to undertake a range of other duties:

> *"… it's both conscious and unconscious, I think quite a lot of practitioners will have things that they need to catch up on" (Rob)*

Participants shared how they relied on clients' DNA to complete their other tasks. Heidi reported that she was 'dependent' on her clients' DNA to function in her role. Rob shared that DNAs were necessary for the system to survive:

> *"Yeah, because if everybody turns up, there's no way I could do everything I need to do in a day. So if you like, we depend on DNAs." (Heidi)*

> *"I think because of the pressures that people are facing now and with higher caseloads. And we are seeing increasing child protection cases. So staff are having to go to a lot of core groups and case conferences and having to produce reports they don't have that time then if the client doesn't turn up they think I can use that time to fill it in." (Ruth)*

> *"… I would actually say that in some respects, there's a built in level of DNAs for the system to operate, because looking at the numbers you've booked in if everybody attended then you'd probably struggle around capacity to record and all the other elements that go with delivery."(Rob)*

While feeling relieved about clients' non-attendance was reported by many participants, it

was also recognised that such a feeling was only short lived. In most cases, clients' non-attendance actually increased practitioner workload. Practitioners were then required to carry out work such as a follow up call or meeting with the client, record client's absence in case notes, update service databases and, at times, contact other professionals, particularly in relation to clients with safeguarding issues. Therefore, in effect, clients' non-attendance increased the workload for many practitioners:

> *"In all truthfulness, if you have a difficult client and you're about to do a very difficult piece of work with them or they're very difficult in terms of their behaviour, if you do get some respite from that, it can be like 'oh they haven't turned up but it's through no fault of my own because I've offered the appointment'. But at the same time there is also then following up or chasing so it's kind of short lived really." (Jemma)*

> *"But in the long run when you look back on it now, because you know you want the person to come back in, so it means you've got to contact the client, rebook an appointment, quite often contacting clients are quite difficult..." (Ken)*

Some participants 'normalised' their clients' non-attendance. Beth shared that clients' non-attendance was an accepted and expected behaviour:

> *"I'm used to it because it's part of the service… so I think it's [clients' DNA] just an accepted part of the daily work really." (Beth)*

The above theme addressed the issue of staff workload and the participating agency's survival was dependent on certain percentage of clients' non-attendance in order to complete expected tasks. On the other hand, participants reported that 'feeling relieved' about clients' non-attendance was a short lived phenomenon. Clients' non-attendance led to additional paperwork and extensive amount of time spent in chasing clients particularly high-risk clients. In the above discussion, I highlighted that the agency relied on clients' DNA

to cope with the workload. Participants discussed about extensive administrative tasks, such as, completing safeguarding referrals and reports that required additional space and clients' non-attendance offered this space. Next, I will discuss about how participants spent their time when their clients DNA.

6.3.3.2 'There is always something else to do'

The sub-theme of 'there is always something else to do' was reported by six participants. Participants responded to the question 'how do they spend their time when their clients don't attend?' by providing a list of different activities which raised an important question of how would they have completed 'other' tasks had all of their clients turned up? Figure 6.5 illustrates a range of activities undertaken during the 'DNA' time.

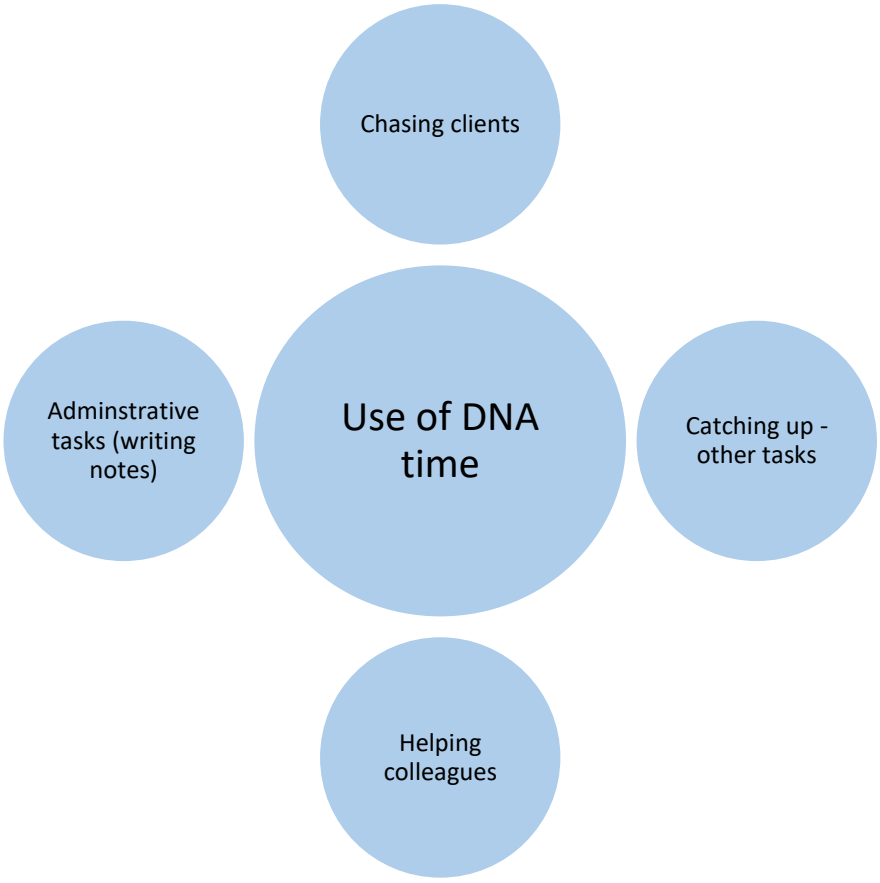


Figure 6.5: Use of DNA time

Many participants reported that they used the DNA time to chase their clients and/or contacting other clients:

> *"… ringing other clients that are on my list, my caseload, because I'll have my caseload clients who I'll want to ring each day." (Ken)*

All participants reported that they had many other things to do during their DNA time. For example, completing paperwork, data entries, supporting other colleagues, setting up group tasks, and contacting clients via phone:

> *"I think quite a lot of practitioners will have things that they need to catch up on whether that's letter to another professional, referral to another service, recording or safeguard a report and actually there might not be an obvious…..there's a deadline coming and they're kind of banking on DNAs, to make, almost that slippage that's in there." (Laura)*

> *"… so, normally, I would, if I've got assessments to put on the system or I've got other clients to ring, I usually fill the time with that. It's very rare for me to just be sitting there unless all the systems have gone down or something which happens occasionally or like phone rings or some other referrals in, usually get myself busy with that." (Heidi)*

The above sub-theme addressed how practitioners spent their time when their clients DNA. Several participants reported that they carried out a number of tasks during these times such as responding to emails, completing assessment documents, supporting other staff members, covering for staff absence, data entry, liaising with external agencies, and dealing with adult or child safeguarding issues. The addiction services in England faced significant funding cuts in the last ten years such as Birmingham reported nearly £4m funding cut in 2015/16 (Gabbatiss, 2019). More than 50% of local council in England reported funding cuts

in their substance misuse service due to government cuts to public health grants (Gabbatiss, 2019). These extensive funding cuts naturally increased the workload of individual practitioners. This had negative impact on clients' engagement and attendance at a community-based agency. The next theme explores participants' suggestions in relation to improving clients' attendance.

6.3.4 What needs to happen: 'Change of paradigm'

This theme captures participants' suggestions about how to improve clients' attendance at their appointments. Participants highlighted both what they or their agency could do to further support clients' attendance. Three sub-themes were identified in the data to demonstrate participants' suggestions; creative engagement, offering a flexible service, and proactive follow up.

6.3.4.1 Creative engagement

Participants proposed a diverse range of ideas to improve clients' engagement and attendance. They suggested that offering more creative interventions would improve clients' attendance. Limited funding and demanding service delivery contracts, where on one hand presented with many challenges to the workforce, it has also encouraged the workforce to think and act more creatively. Figure 6.6 shows a range of creative engagement strategies suggested by the participants as discussed below.

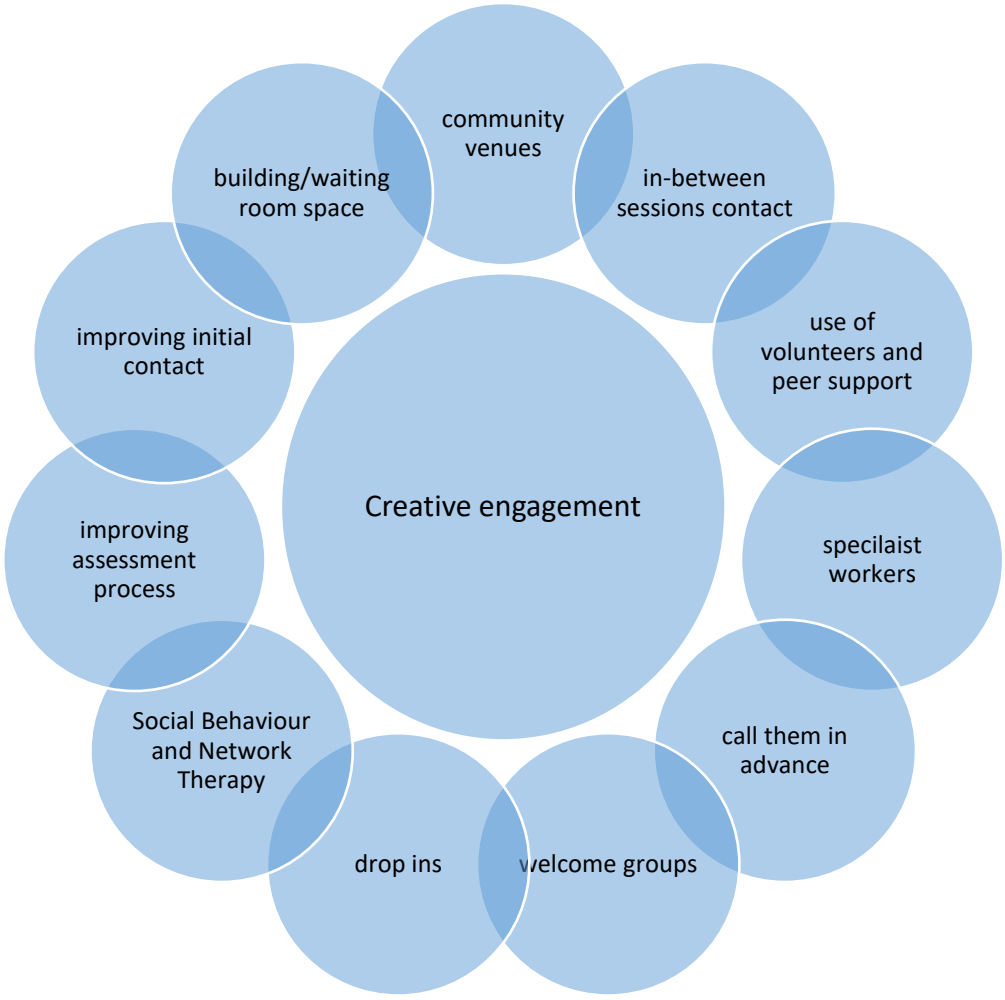


Figure 6.6: Creative engagement strategies suggested by practitioners

Rob talked about the need for a more dynamic view of attendance and challenged the traditional out-patient medical model-based appointment system. He also recommended a change of paradigm – moving work from inside (the therapy room) to outside (the real world):

> *"… [we need to be] taking a much more global view of people being out in the world trying to recover, and what we do to engage in their world, I think that's the kind of change in our…paradigms…is it [recovery] happening in here [counselling room] or is it happening out there, and I guess for me, it's not happening in here, it's more out there, that's where it happens…I think…it isn't just about when they come here it's*

about what's going on for the rest of the week and what we're doing to affect change in their environment outside." (Rob)

Dave and Heidi suggested being creative in their initial contacts with clients. Many clients experienced nervousness and anxiety about attending services first time and meeting up with professionals and discussing their life stories:

"… if it's early days, [it] would…be easier to meet at a coffee shop or somewhere closer to home kind of thing." (Dave)

"…[We need to] encourage them, remind them, try to get them to come… to drop in, try and not just sell it as a session but to come in for a cup of tea before and tie them in with a group or something, try and offer more of a package than just coming in for a one to one session (Heidi)

Many participants supported Dave's suggestion about engaging clients in a number of activities instead of just one to one sessions. These activities included drop-in sessions, walking groups, social mornings, support groups, and psycho-education groups:

"… it's not just about one to ones but groups as well and it goes hand in hand. So if they give that whole package to the client from the very start that should encourage them to come in and see if they can access a range of support from us." (Ruth)

"… things like coffee mornings, welcome groups, meet and greet groups, things like that even if it's run by volunteers so people coming in and getting a taste of this is what you're going to get." (Kim).

Jemma and Leyla talked about using community venues as a creative way to reduce clients' travelling distance to the main service centre. Emily reported that offering group-based interventions to clients who were waiting for their first appointments after assessment sessions helped clients to attend their first sessions. She talked about a specific group offered by her service site - Welcome to Recovery Group- significantly improved clients attendance at their first sessions.

> *"… that's where they're informed about what we deliver, the type of services, the counselling that we offer, drop-in groups, so it's a bit of an information welcome to the service group and at that point they are told who they are allocated..." (Emily)*

The initial contact deemed an important factor in relation to clients' attendance. The participants suggested being more creative at the assessment stage, that is, instead of only collecting information it could be used for building therapeutic relationship with clients. Anne specifically raised her concerns about how much paperwork was required to be completed in an hour's slot:

> *"… once the assessment is completed, all the outcomes, and the stars and the risk assessment, I'm sorry they cannot be done to a good standard in one hour…" (Anne)*

> *"... It's not about over loading clients in the first meeting during assessment…. We should work on client's motivation, developing rapport and relationship... only then clients will come back to see you… there is so just much paperwork…" (Heidi)*

> *"… clients don't like coming into service and being bombarded with questions so what I encourage the practitioners to do is see the assessment as a process not as a form to fill in. Being creative about how you ask your questions, don't sit with a paper in front of your face, ticking boxes..." (Kate)*

Heidi and Leyla talked about the benefits of ‘drop-ins’ - no appointment required and clients can come in during the office hours to spend time with other clients and/or engage in activities such as playing board games, watching a movie, playing computer games with others. Drop-ins were supported by support workers, volunteers and peer support:

> *“… I think that really helps because I think if some people drop in and if they get quite involved with the drop in they're more likely to want to attend…” (Heidi)*

> *“… you'll get people who won't attend their appointments but will attend drop in and then eventually when you come in to drop in and have a chat with them, they are more likely to want to come in for one to one appointments…” (Leyla)*

Participants explored the benefits of ‘welcome’ sessions offered after the initial assessment meeting whilst clients were waiting for their allocations. New clients were supported to engage with existing clients, volunteers and peer support:

> *“… they've been quite good at coming to the welcome session…… when they have that welcome group they meet someone that's been in service - that's quite good for encouraging them.” (Beth)*

Kim suggested that volunteers can be used to offer more engaging initial contact:

> *“… there's going to be trepidation, fear of what's going on but if you were invited by us, come have a cup of coffee, we're all volunteers have a chat, see what you think, see if this is the service for you, you'd be so much more likely to come and think you know what? They're alright and then you would probably engage.” (Kim)*

The organisation's building was highlighted by the participants as one of the factors for clients' non-attendance. The waiting room is the first spatial experience for clients and practitioners shared that offering a therapeutic, warm and welcoming environment were important factors in enhancing clients' engagement:

> *"… [the] client would want to have somewhere where they can sit down and be comfortable ..." (Jemma)*
>
> *"… a space which is not full of scary posters such as crime stoppers or health warnings but also welcoming ... paintings or flowers... not like GP or dentist waiting rooms…" (Heidi)*

Forgetfulness was considered by many participants as the most common reason for clients' non-attendance. Beth and Laura suggested calling clients in advance as a useful method to improve attendance rate:

> *"… ring them in advance in the morning, if they're coming to see me in the afternoon. Nudges for people who need it." (Laura)*

They also suggested calling in-between sessions would help many clients with their recovery plans as well as their engagement with the service:

> *"… I phone my clients because that's what they usually need, about validating telephone interventions, about encouraging people to have more than one intervention in a week..." (Laura)*

The use of volunteers and peer support by the agency had improved the overall service delivery and particularly clients' engagement:

> *"… we've gotten a bit cleverer in utilising volunteers and peer support more and that's what we offer in terms of the whole package of care." (Ruth)*

> *"… I think xxx (service name) have put measures in to try and avoid the DNA. So we have volunteers and peer support so we'll go out with practitioner to see in their home if they are struggling to engage them" (Emily)*

To further improve BAME and younger clients' attendance some participants suggested a specialist worker role to support outreach service provision. Ruth specifically raised gaps in service delivery in relation to working with BAME clients:

> *"… Do we have staff that speak different languages. Have we got literature that encourages people to understand what we offer as a service? and the whole education, how we sell it? With the xxx (service project name) we went on the stance of how alcohol affects your health and trying to engage people in service." (Ruth)*

Kim suggested using internet-based interventions might be more effective for younger clients:

> *"… maybe some people would work better if it wasn't face to face for this generation especially in the younger people, that are so good at texting and skyping and all that sort of stuff maybe they prefer that just a tiny bit of anonymity but still get their needs met…" (Kim)*

Rob shared benefits of using Social Behaviour and Network Therapy (SBNT) and creating

supportive network around client in their real life beyond an hour-long session with a practitioner:

> *"… you need to be involved in social engineering, you need to change the environment outside. You can't do that purely from your appointment room, you've got to be in contact with the friends and family that support them, the other professionals that are supporting them. you need to try and change the dynamics of the people around them and try and harness the support." (Rob).*

Practitioners suggested a range of creative strategies to improve clients' engagement and attendance such as offering drop in sessions, phone contact in-between sessions, improving assessment procedures. Some participants also suggested offering local satellite services such as GP surgery, community centre, and home visits in order to improve clients' attendance. Travelling distance was one of commonly reported issues by clients for their non-attendance and offering accessible venues would improve clients' engagement. Some practitioners also suggested that involving family and friends in clients' treatment would also improve their engagement and overall alcohol reduction goals. According to Copello et al. (2002) developing and mobilising positive social network around clients would positive impact their treatment outcomes. Previous research has shown effectiveness of Social Behaviour and Network Therapy in helping people with alcohol addiction (UKATT research team, 2005). In the next section, I will discuss the sub-theme of offering a flexible service in order to improve clients' engagement.

6.3.4.2 Offering a flexible service

Participants shared that flexibility in their approach to clients' engagement was essential. They suggested different ideas to improve clients' engagement such as flexible appointments, telephone interventions, allocation of practitioners and matching practitioners with clients' specific presenting needs (see Figure 6.7 below).

Figure 6.7: Offering a flexible service

Participants suggested a flexible approach to addressing clients' needs in order to improve clients' attendance. Clients present a diverse range of needs based on their individual circumstances hence service provision should be flexible enough to meet individual clients' needs. Several participants suggested flexible appointments such as evening, weekends or school friendly times:

> *"… choice of appointment, some people might be working so we do evening sessions, some people have children, and can you bring the kid, trying to work with that person as an individual. I think it would just be to continue to offer choices around the appointment time, location, choice of worker if that's something they've specified they want male female as reasonably as possible, listening to them, trying to find out*

what their needs are reasonably early on so you can meet those…" (Kate)

"… more evening work would be beneficial to those clients who struggle with childcare and employment and weekend service I think. Being closed on a Saturday and Sunday makes it very difficult for certain clients to be able to access the service so a regular question at assessments is ….are you open weekends?" (Emily)

Participants highlighted the importance of allocating practitioners to clients in a manner where clients' specific needs were considered when allocating practitioners. Emily and Ruth discussed that clients should be able to request to change their practitioners and there should be enough flexibility in the system to offer such service in order to improve clients' engagement:

"… we have had clients come through who say I don't feel I can click with my practitioner and there have been DNAs leading up to that …….. so I think crucially, very crucial to try and tailor what practitioner you have for what client…" (Emily)

"… if people are not happy with their key worker they have a right to change them…and there should be enough flexibility within the system to do this… " (Ruth)

Participants suggested that using phone-based interventions could further improve clients' engagement and attendance rate. Clients could be called during their allocated appointment time in case of their non-attendance to offer support with their drinking and help to attend their next appointment:

"… I think sometimes if someone doesn't turn up, sometimes phone appointments can be quite helpful to maybe build that relationship again with the practitioner but also to help build their motivation…" (Heidi)

"… okay you forgot your appointment, let's do it now [over the phone] because from my point of view that's not a DNA, you've delivered the intervention by a different means, on the telephone and you've kept them engaged…" (Rob)

Several practitioners suggested that offering a more flexible service would improve clients' engagement. This included, considering specific client needs and preferences at the practitioner allocation stage, flexible appointment system, and using telephone-based interventions. Booth and Bennett (2004) reported that receiving telephone prompts improved clients' engagement at addiction service. Working with a suitable practitioner is crucial to establishing an effective therapeutic working alliance. This has been highlighted in the previous research that effectiveness of therapeutic relationship is crucial to clients' treatment engagement and outcomes (McCallum, et al., 2015; Nordheim at al., 2018). In the next section, I will explore the practitioners' suggestion regarding proactive follow up after the initial referral and clients' non-attendance.

6.3.4.3 Proactive follow up

Many participants suggested that proactive follow up after the referral and clients' non-attendance is crucial to improve clients' attendance. They suggested different ways of being proactive in their approach and attitude to reach out to clients such as text message reminders, prompt follow up, community outreach and perseverance (see Figure 6.8 below).

Figure 6.8: Types of proactive follow-up

Emily shared an important step – learning from clients' previous experiences to improve the service delivery:

> *"… [we discuss] what didn't work before, so that we can put things right….[to support their engagement]..." (Emily)*

Many participants discussed the importance of using text message reminders particularly as forgetfulness was the most commonly reported reason by clients for their non-attendance. Participants shared that sending text message reminders were very effective and easy because the computerised system of sending messages was linked with their clients' database:

"… we've got the automated text reminders which is good so we don't have to be ringing and texting ourselves, it should just go out and we can set it the day before or just the hour before like they can have quite a few if they need it, I think that works quite well with people because they've got that on their phone instantly to remind them..." (Beth)

Reducing waiting times between referral and first appointment was deemed crucial. As discussed above long waiting times between referral and assessment sessions and then between assessment sessions and first treatment sessions negatively impact clients' attendance and engagement. Participants highlighted the significance of seeing clients promptly after their referrals:

"… if someone is motivated you need to start treatment then and there, you need to have that first conversation about it soon as possible. I think if there's delays it does lead to people losing motivation thinking the service isn't gonna help them being frustrated because having reached out for help but now have to wait, that's a big barrier." (Jemma)

"… they might have spent ten years trying to make that decision today you need to get some work in there today otherwise they'll just go back to well if they don't care I don't care because that's how it can seem to some people if there's longer waiting lists…" (Kim)

Prompt follow ups not just after the referral buy also after the client's DNA improve clients' engagement and attendance. Rob suggested prompt follow up after client's DNA using different strategies such as a phone call, a text message or a letter:

"… I would expect workers to do this, to be proactive, if not, you know, looking at

other means, text the person, ring them initially - if they don't answer, text them …" (Rob)

Many participants suggested that being proactive in reaching out to clients in their communities improves clients' engagement. Offering support in their (clients') homes by arranging home visits or seeing them in their local community-based venues will further help their clients to engage with the service as well as engage in their recovery process:

"… the whole thing I've struggled with is location where we bring everybody in to the service to be seen, where[as] I'm very much about outreaching to the community in your various locations so people come and see us there because people are more likely to come see you at the community rather than in a building located in the centre of town." (Ruth)

"… seeing people in their communities is massive. I think the more we are within the community the less travelling [for clients] which will make it easier for clients to attend…" (Sarah)

Rob, Kate and Jemma shared how home visits could be very helpful strategy to engage clients with their service:

"… there's a good case for it [home visits] and rather than having the next six appointments that aren't attended by the person before we discharge them, why don't we offer one home visit and get them engaged, do something with them." (Rob)

"…trying to meet their needs as reasonably as possible so if somebody's saying

they've got a disability and can only have home visits, try and meet them in their houses..." (Kate)

Several participants talked about 'not giving up' on their clients after their non-attendance. Practitioners understood that DNA was a part of many clients' recovery journeys. Their acceptance of clients' challenges and difficulties in their quest of making significant behaviour and life style changes offered a non-judgmental and welcoming environment to their clients to re-engage with the service:

"… and we don't just say you DNA'd one appointment that's it we give them another chance to follow up…" (Jemma)

"… it's just not giving up, do you know what I mean, talking to them… remembering that when you're in active addiction each day can be very different, even though it's all the same, it can be very different, you never know..." (Sarah)

In this section, I have reported practitioners' suggestions about improving clients' engagement and attendance. Many practitioners recommended more flexible service delivery, creative ways of engaging with clients and prompt follow ups in order to address a range of issues that impact clients' attendance at a community-based alcohol service. The practitioners' interviews explored participants' perceptions of reasons for clients' non-attendance of appointments, participants' experiences of their client's non-attendance and attendance improvement suggestions. In the next section, I will discuss practitioners' interviews in light of the aims of this qualitative strand. An integrated discussion of the findings will be presented in Chapter 8.

6.4 Discussion

The practitioners' strand set out to explore their perspectives with regard to their clients' reasons for non-attendance and how their attendance can be improved. The main research questions were: What are the main reasons for clients' non-attendance at appointments within a community-based alcohol service in practitioners' views? How do practitioners experience their clients' non-attendance – exploring their (practitioners') thoughts, feelings, interpretations and behaviours? What do practitioners think will improve their clients' attendance?

Many practitioners reported that certain client groups were more likely to not attend their sessions. These included younger clients, BAME groups and clients with complex needs. The above findings highlighted that the agency needs to address gaps in their service delivery in relation to minority groups such as, younger, BAME and clients with complex needs. The clients' demographics information in Chapter 5 demonstrated that majority of the clients were White British and between 25-59 years old. Many practitioners reported that perhaps more traditional interventions were less effective with younger clients. The difference between an 18-year-old client with hazardous binge drinking problem and a 55-year-old physically dependent on alcohol client, require different 'treatment' approaches. One of the key issues here is that in one situation, practitioners need to work on 'potential future risks' of excessive drinking in case of younger clients, and on the other side they are required to work with clients living with significant harmful consequences of their excessive drinking. In the latter case, harms of excessive drinking are not just imaginary or in distant future, but they are real and present. It seems like that the practitioners had developed particular skills and competencies to work effectively with older, white and alcohol dependent clients. This highlights gaps in the practitioners' training, skillset and knowledge in relation to working with younger and BAME clients. The existing literature shows that BAME clients would more likely to not attend mental health and social care services (Leowenthal et al., 2012; Greenwood et al., 2015; Greenwood et al., 2017). For Leowenthal et al. (2012), mental health professionals' lack of understanding of cultural factors of ethnic minority clients negatively impact their accessibility and engagement. In addition, negative impact of language barriers also contributes to ethnic minority clients' lack of engagement with psychological services (Costa, 2011). It is crucial that the agency

offers specific training support to its practitioners in order to further enhance their competencies to work with a diverse range of clients (Mahmood, 2020).

Several practitioners highlighted a number of issues that negatively impacted practitioner-client therapeutic relationships and, therefore, adversely impacted clients' attendance rates. These issues included; for example, staff burnout, funding cuts, limited resources, long waiting times between referral and the first session, and lack of community outreach services. Many practitioners considered practitioner-client therapeutic relationship was crucial to clients' engagement with the agency. This has been highlighted in the previous research that effectiveness of therapeutic relationship is crucial to clients' treatment engagement and outcomes (McCallum, et al., 2015; Nordheim at al., 2018). The clients' motivation to drink (West and Brown, 2013) and to change (Miller and Rollnick, 2013) is considered a crucial phenomenon in understanding clients' drinking behaviour and recovery. Similarly, practitioners' motivation to work with their impacted by compassion fatigue (Sprang et al., 2007). This study introduced a novel working model of 'co-created motivation', that is, both the client and practitioner's motivation to work together impacted the client's attendance rates. Co-created motivation refers to interacting forces between a practitioner and client in a counselling room. Practitioners and clients proactively impact each other and impacted by each other (Wollants, 2012). Practitioners suggested that creative engagement styles, offering a flexible service and proactive follow ups could improve clients' attendance. This included offering a flexible and creative interventions in order to reach out to clients such as drop ins, telephone interventions and prompts (Booth and Bennett, 2004), text message reminders (Hasvold and Wootton, 2011; Gullo et al., 2018), involving families and friends in clients' treatment (Copello et al., 2002), offering local community-based satellite clinic to reduce travelling distance (Jackson et al., 2006), and reducing waiting times and administrative delays (Booth and Bennett, 2004).

6.5 Chapter summary

In this chapter, I have presented the findings of practitioners' semi-structured interviews. Practitioners explored a number of reasons for clients' non-attendance including certain client-related patterns and their experiences of clients' non-attendance. Practitioners' interviews offered novel insights into understanding client's engagement and

non-attendance, that is, non-attendance is a relational issue and belongs to both parties – practitioners and clients, and that a certain percentage of DNAs are required for treatment services to cope with the workload. Considerable funding cuts, lack of sufficient resources, extensive paperwork, safeguarding protocols and demanding service delivery targets led to increase in the workload for practitioners and clients' DNA time was used to catch up with overdue tasks. Practitioners suggested a range of steps in relation to improving clients' engagement and attendance at a community-based alcohol agency.

In the next chapter, I will present the findings of clients' focus group.

Chapter 7 Findings – Clients' Views

This chapter presents the findings of the focus group with clients (n=8) exploring their views about people's non-attendance at a community-based alcohol service and their suggestion to improve clients' attendance. The key aim of this study was to explore clients' perspectives with regard to clients' non-attendance. This strand set out to address the following research questions: What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service? How do clients make sense of their 'non-attendance' – exploring their thoughts, feelings, interpretations and behaviours? What features do clients suggest may improve their attendance?

As detailed in chapter 4, template analysis (King, 2012) was used to analyse the focus group data. Three main themes were identified:

1. Reasons for non-attendance
    I. Client related factors
    II. Service-related factors
2. Client-practitioner relationship
3. How the attendance can be improved?

7.1 Participants demographics

Eight people took part in the focus group. Their demographics details are set out in Table 7.1 below.

Table 7.1 Participants' (clients) demographics

	Name pseudonym	Age	Gender	Ethn-icity	Religion	Employment Status	Accommodation Status	Relation-ship Status
1	Mark	45-54	M	W/B	No Religion	Unemployed	Living in care	Civil Partnership
2	John	45-54	M	W/B	No Religion	Regular Employment	Private rented Property	Single
3	Sue	45-54	F	W/B	Christian	Unemployed and seeking work	Property owner	Single
4	Mandy	45-54	F	W/B	No Religion	Homemaker	Property owner	Separated
5	Chris	35-44	M	W/B	No Religion	Regular Employment	Living with relatives/friends	Single
6	Tina	55-64	F	W/B	Christian	Regular Employment	Property owner	Married
7	Emily	25-34	F	W/B	No Religion	Unemployed	Social housing	Single
8	Steve	65-74	M	W/B	Christian	Retired from paid work	Property owner	Married

In summary, eight participants attended the focus group comprising four male and four female clients. All participants were White British, three identified themselves as Christians, three reported being in regular employment, four identified as property owner and three reported as married/in civil partnership. All participants were registered as clients attending the agency for support to reduce their alcohol use. They had all been with the agency for more than three months. One participant was aged between 25-34 years age-range, one between 35-44, four between 45-54, one between 55-54 and one between 55-64. All clients who participated in this strand had lived experiences of long-term addiction and treatment

engagement and attendance.

Next, I will discuss the findings of clients' perspectives encompassed in three main themes: i) Reasons for non-attendance, ii) Client-practitioner relationship, iii) How their attendance can be improved?

7.2 Reasons for non-attendance

Participants shared a range of reasons for clients' non-attendance which can be broadly divided into client and service-related factors.

7.2.1 Client-related factors

Participants highlighted certain client-related factors such as denial, poor emotional health, relapse and other commitments (for example, committed to attend other appointments) related to clients' non-attendance (see Figure 7.1 below).

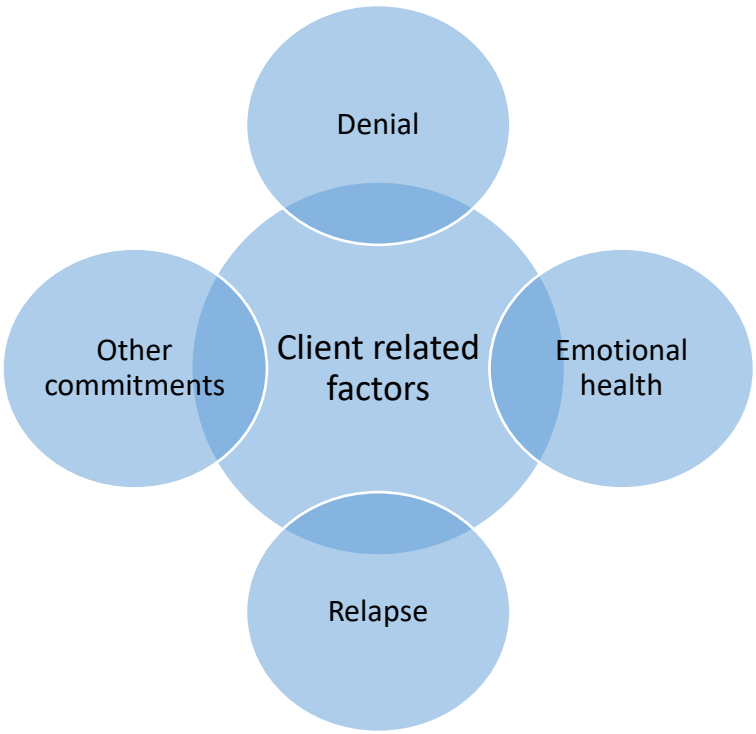


Figure 7.1: Client-related factors

Five participants named their denial of drinking lapses as a contributing factor for their relapses and non-attendance. Denial was considered as a common phase in clients' recovery particularly at the initial stages. Mark shared the importance of family and friends' support in starting their recovery even when someone was reluctant to attend:

> *"…Even if they were doing it [attending service] for others, it helped them to address their addiction particularly as they were in denial regarding their drinking issues". (Mark)*

Five participants shared their thoughts about their denial of drinking:

> *"I just didn't admit to myself." (Mark)*

> *"Didn't believe I was unwell, didn't believe I had an addiction or a problem but I couldn't face going to these people again [practitioners]." (Sue)*

> *"It's all part and parcel the addiction and denial that we all have." (Tina)*

> *"You lie to everybody including yourself." (Steve)*

> *"I think everybody's started the journey in denial. We often just do it [stop drinking] to prove to our… [families].. we don't really want to do it [initially]." (Mandy)?*

Many participants who attended alcohol support services for their addiction issues also had other mental health issues such as anxiety and depression. Low mood and social anxiety were reported as the main contributing factors that negatively impacted clients' attendance:

"I've noticed people come a couple of times and then miss several……because they're depressed, they can't face it." (John)

"… because depression, anxiety, that could lead to missing appointments." (Chris)

"… for me it was my mental health…. Some days I felt so anxious that I couldn't face any professionals." (Emily)

"… bipolar, so when I'm on a high I don't think I need any help, [I] think I'm indestructible, then I realise when I come off that high, I feel really shitty about myself." (Steve)

Participants talked about feeling particularly anxious when they first started their treatment. Six participants shared that, in their experience, many people drink excessively to deal with their social anxiety and nervousness around others particularly strangers. It could be argued that attending an addiction service could be very daunting for some people:

"Because I guess it's tricky when you first come to a service…. it's a new place and it's very nerve racking." (Steve)

"It's very daunting when you first start…. I was so worried when I first started coming here… I don't think my practitioner had any sense how I was feeling. They didn't check how I was. They were worried about their paperwork." (Sue)

"For me I put myself on a destructive path where I'll either self-harm or drink alcohol or whatever it is to get me through rather than having the confidence to say you know what I didn't come I'm sorry I missed my appointment and face it but I just bury

my head like I do everything else and it just disappears like everything else, I don't chase it up and support myself with it." (Emily)

Four participants shared their experiences of how drinking relapses negatively impacted their attendance. Either they did not wish to attend when under the influence or feeling ashamed led to their non-attendance. Many clients relapsed particularly at their early stages of recovery which led to their higher non-attendance percentage:

"Lots of times I didn't turn up because I thought I'd had too much to drink." (Mandy)

"… guilt and shame that I'd lapsed and I didn't try to actually acknowledge what was going on. I was scared to talk to anybody." (John)

"I suppose if it's a lapse then maybe it's the guilt that goes with that, feeling ashamed and all the other feelings that we pile on ourselves. But also if it's a full blown relapse then it could be the person is still bingeing and the world just seems to exist at the bottom of a bottle kind of thing." (Mark)

Participants talked about 'other commitments' such as other appointments, for example, GP, hospital, mental health, social services, or Job Centre Plus impacting their attendance at an alcohol service. Participants shared that it was very common that many clients with alcohol issues also had other associated challenges such as health, housing, and financial. During treatment many participants were required to attend several different appointments with different professionals;

"… at one point I was seeing six different professionals in a week and sometimes it was so draining… talking to different people [saying the] same thing again and again.

I was seeing my psychiatrist, my alcohol worker, my housing support, probation officer and detox nurse all in one week…I just could not cope with all that… and I missed many appointments with many professionals." (John)

"… I missed my meetings with my [alcohol] practitioner here because I had to go to attend Job Centre Plus [appointments] for my benefits…" (Mark)

John highlighted an important issue that points out a significant gap in how different services operate in the wider treatment or support system. Lack of a coordinated inter-agency approach to clients' recovery journeys among different service providers means that clients have to go through several service-registration and assessment processes and, as John said, clients will have to repeat the same information several times with different professionals. The wider treatment or support system relies on specialised service provisions such as addiction, housing, social support, mental health, physical health, and others, and these divided services rely on breaking down/splitting the complex human experiences into specialised problem-driven segments. Mark identified a different dimension of his experiences where he had to prioritise more demanding needs such as accessing his benefits by attending Job Centre Plus instead of alcohol support agency. If clients are faced with a choice to prioritise their attendance at two different agencies, then it is more likely that they would choose more pressing appointments.

It is important that different service providers develop a meaningful partnership approach at regional level including, joint information sharing protocols, sharing assessment and treatment planning information, joint reviewing of clients' progress, and more specifically where possible liaising with different professionals involved in the clients' treatment regarding appointment bookings. In the next section, I will discuss service-related factors that impact clients' engagement and attendance at a community-based alcohol agency.

7.2.2 Service-related factors

Participants explored certain service-related factors linked with their non-attendance such as allocation of practitioners, the agency's assessment process, environment of the agency and transport issues due to service location (see Figure 7.2 below).

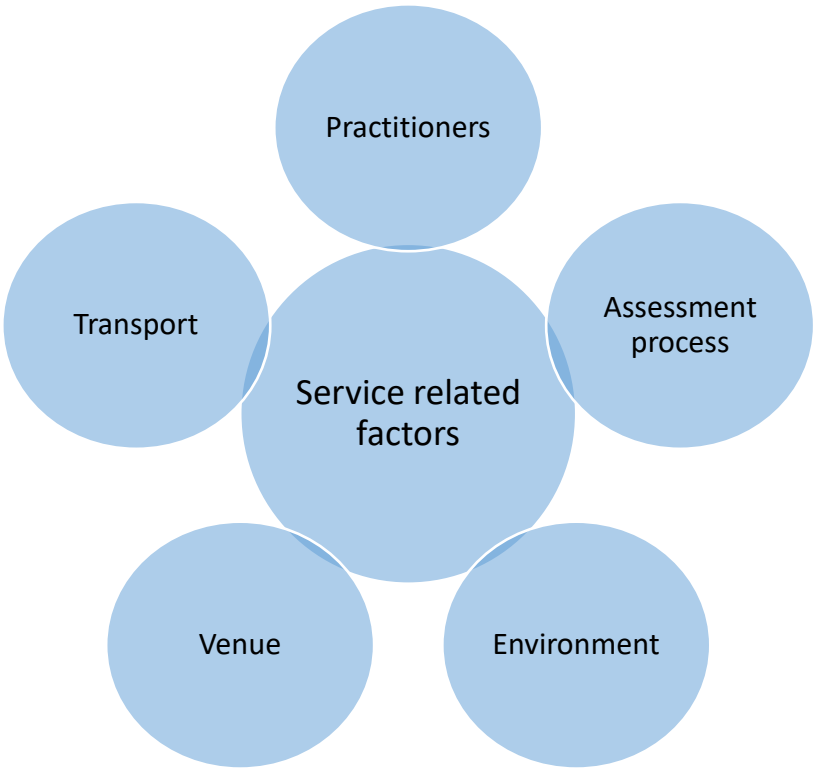


Figure 7.2: Service-related factors

Several participants expressed their concerns about lack of flexibility or choices available in relation to their allocated practitioners. They recognised that it was due to funding limitations and the limited number of staff available. They also expressed concerns about the lack of clarity with regard to process of changing practitioners. All eight participants stated that they preferred to work with practitioners who had personal experience of addictions. The sub-theme, practitioners' personal addiction history, is discussed separately under the practitioner-client relationship theme (section 7.3):

"It really matters who you work with… who is allocated to you… it's like a lottery sometimes…"(Sue)

"... I don't know if there is any process of changing practitioners. I am working with someone and to be honest I am not very happy with her. I don't think she is very experienced….I don't want to be too harsh.. but she is new.. do not think she really understands addiction…"(Mandy)

"… I know there are not enough staff for all of us to pick our preferred one…" (Chris)

Six participants expressed their concerns about the 'box ticking' approach (an activity performed to serve a bureaucratic function than to accomplish any meaningful purpose) during assessment processes. Assessment was considered an important stage where not only practitioners assessed their clients' needs in order to develop a client-centred treatment plan, it was also the first meeting between a client and a practitioner - a starting point of their therapeutic alliance. Often practitioners were under pressure to complete a long assessment form in addition to several outcomes-based questionnaires as required by their service delivery contracts. Four participants reported their experiences of initial assessments as intrusive and insensitive:

"… I hated it.. it was like being questioned by police for a serious crime. Questions like how many children I have, how old they are, where do they live, which school they go to… as if I committed a crime.. I really need the detox when I first contacted the service otherwise I would not have ever came back after that experience of being interrogated." (Mark)

"[During the assessment session] far too many personal questions being asked in a robotic way. I think they [practitioners] need to learn to be more human specially when the new clients are so nervous, ashamed and not even sure this is really what they [clients] want." (Emily)

"… all they [practitioners] are doing is sitting there ticking boxes and saying how do you feel? On a scale of one to ten. I feel crap, but I'm gonna lie to you, I'll give you a 9 [10 being feeling really good]." (Chris)

Chris highlighted the significance of effective practitioner-client encounters and this supports the views of practitioners (Chapter 6) that meaningful relational experiences are crucial to clients' engagement and attendance at their treatment sessions. Privacy was important for clients to feel comfortable and attend their appointments. Three participants shared concerns about walking into a building with clear signs that it was an addiction treatment service. Instead, they preferred a multipurpose site to avoid being labelled as someone in addiction treatment. All participants liked that their existing service site had no signs outside the building and it was a multi-purpose building:

"… another one for me is if you're coming to the environment and a lot of the time you are very nervous…… I have seen people I know here, which is quite amusing because I went to school with them but the fear of seeing somebody you know." (John)

"... it is nice out here because there isn't a big blazing sign saying this is... an addiction service." (Emily)

"… it's daunting, the fact that you're admitting it, but you don't want blazing saddles saying to everyone in XXX (name of the town) that 'hey I'm an addict and look at me." (Steve)

Participants explored the significance of therapeutic environment in relation to their attendance. They compared the previous and the current building physical environments and highlighted how much it had made a positive impact to move into a new, well presented, and welcoming environment on their attendance:

"… for me this time the environment made a massive difference because I tried XX (service name) before when it was down the bottom of the road….. bars on windows and it was like woah hold on a minute… You had to walk in the tiny little hallway, they had to buzz you in, you had to go up these tiny rickety stairs and the room itself was just absolutely tiny, it was in this closed environment and when you're an addict [alcoholic] and in that position, and you maybe withdrawing, that to me was really scary. Many times I just didn't come to my appointments because I didn't like the building..." (Sue)

"… the environment to me was massive, if I was to walk down here on the day that I came and I saw outside there was a group of people who were in the same predicament as me but with cans in their hand, I definitely would not have walked in, it just wouldn't have happened..." (Emily)

"… so I saw the bars in the windows and I thought this is a medicated prison, I didn't see it as help I thought they're gonna make me say and face things I don't wanna face so I'd relapse...and miss my sessions" (Chris)

All clients in the focus group stressed the importance of therapeutic environment of the agency's building. Chris used a powerful metaphor 'medicated prison' to describe his experiences of the agency and linked it with negative projections on practitioner-client relationships, relapses and non-attendance. Other clients also stressed that both internal and external building environment such as counselling room paint colour, decorations, information posters in the reception areas, size of the room, building temperature and light, and external entrance, made significant impact on clients' engagement and attendance at the agency.

Participants also talked about transport issues and cost as one of the reasons for their non-attendance. Many alcohol service clients were out of work or involved in low income employment due to their addiction issues. Limited income meant not having enough funds

to buy a bus ticket at times or phone credit to inform their practitioners that they were unable to attend:

> *"… it doesn't matter where you live within the borough, if you haven't got the money… you can't attend..." (Mark)*

> *"…I work and I still don't have the money for buses sometimes…. Once I didn't have any money to top up my phone to call my practitioner [to say] that I can't come that I have no money to buy a bus pass…" (Chris)*

The above theme 'reasons for non-attendance' was divided into two subthemes; client-related factors and service-related factors. Several clients highlighted a range of client-related factors for their non-attendance such as, mental health needs, relapse, denial and multiple appointments at the same time with different professions. In addition, clients highlighted many 'service-related factors' such as lack of flexibility in allocation of practitioners, intrusive assessment process, therapeutic environment (Sanders and Lehman, 2019; Morrey et al., 2020), and transport challenges due to agency's location (Jackson et al. (2006). The next theme will explore the importance of client-practitioner relationship in relation to clients' attendance.

7.3 Client-practitioner relationship

Participants explored the importance of a therapeutic relationship in relation to their recovery and attendance. Trust and therapeutic connection were highlighted as two important aspects of an effective therapeutic alliance. Some participants named the integration of two different dimensions, being compassionate and challenging ("kick up the arse"), as useful for their engagement. Lacking empathy and box ticking or lip service attitudes were considered as detrimental to trust and effective therapeutic engagement. Practitioners' personal history of addiction was highlighted as the single most important factor by all the participants. All participants preferred to work with someone with their own history of addiction or living with someone with addiction issues.

Participants named therapeutic alliance as an essential factor for their engagement and attendance:

> *"… I would say it's paramount, not naming any names but there's one person here that had I been put with that particular person, I would've either not attended, or I would've had to have said I'm sorry but I want to see somebody else so I think the relationship is paramount for compliance and for attendance…"(Mark)*

> *"… I had absolute trust in X (practitioner's name). That's one reason I would never miss an appointment because of that relationship which was paramount." (Steve)*

> *"…when the connection is not there, one of the possible reasons of people miss their sessions."(Mandy)*

Mark, Steve and Mandy strongly expressed their views that client-practitioner therapeutic relationship was crucial for their engagement and attendance at appointments with their practitioners. Other clients also commented that without an effective therapeutic relationship the process of recovery could take longer or be adversely disrupted. Sue and Mandy listed a number of factors that contribute to stronger working alliance such as trust, compassion, unconditional acceptance, and commitment to their working relationship.

> *"… It's different attributes in a person. So some people need a compassionate arm on the shoulder a lot, and some people do need a kick up the arse, and they know that, people know about their own personality…" (Steve)*

> *"[I needed someone to] give me the kick up the arse, because I did need arse kicking."(Chris)*

"… for me… it's someone who is not afraid of me or clients to say things as they are… I really don't like those who are just too careful… I can't trust them…" (Emily)

Participants talked about different factors that impacted their therapeutic alliance. Being compassionate, trustworthy, honesty, being open, not afraid to say things as it was and appropriately challenging were highlighted as important factors. Some participants explored unhelpful factors that negatively impacted a therapeutic relationship such as a lack of empathy, a box ticking approach to needs' assessment system or lip service attitude and hiding behind the mask of professionalism and lacking personal connection:

"I don't know for me it's like a script, it can be for some practitioners just a script..." (Mandy)

"… I have worked with many people over the years…there are some who are just so rigid, distant and robotic…If I can't see them as a person. I am not going to open up…" (John)

"…for me if the other person can't see my point… can't understand me ... I am not going to waste my time to come and see them again..." (Sue)

Personal addiction history was considered by all the participants, as the single most important issue that positively impacted the client-practitioner relationship. All participants shared their preference to work with someone with their personal history of addiction;

"… I was clearing out the wardrobe in my bedroom and I found my stash of empties that I didn't even know were in there and it was like being hit in the face and I spoke to X (practitioner 's name) about it because I knew she would understand because she had own history of addiction…"(Sue)

"… Because I think it's universal, alcoholics talking to other people if they haven't been through, people outside the addiction… just don't understand. It's not their fault, it's impossible for somebody who hasn't been through our experiences to be able to appreciate…" (John)

"… it's that personal point where you are in your recovery. When your brain is muddled up, because it is muddled, you don't see the same as when it's not… only those people who had addiction can really understand us…" (Emily)

In the above excerpts, clients discussed about the importance of client-practitioner working alliance. In clients' views, person-to-person therapeutic contact was the heart of client-practitioner relationship instead of distant, rigid, manualised, robotic and scripted approach of some practitioners. Clients stated that being trustworthy, direct, compassionate, appropriately challenging, careful self-disclosure on behalf of practitioners, and personal experiences of addiction greatly helped in fostering effective client-practitioner relationships. Sue discussed about the significance of an empathic relationship with her practitioner and that it was the key to her attendance at her sessions (Martin et al., 2005; McCallum, et al., 2015; Nordheim at al., 2018). In addition, clients suggested a range of steps to improve clients' engagement and attendance. Next, I will discuss these suggestions.

7.4 How the attendance can be improved

This theme addresses participants' suggestions in relation to improving clients' attendance. Many viewed non-attendance as a symptom of other possible underlying factors; issues related to clients such as relapse, mental health, financial problems, and therapeutic engagement with their allocated practitioners. Several participants suggested about having a system to provide an ongoing feedback to the management about their experiences of working with a particular practitioner. Some participants suggested written anonymous feedback whereas others disagreed about filling forms and explored possibilities of speaking with someone in management in confidence about their experiences:

"….after a session, do a questionnaire and see if you're comfortable with this person [practitioner] … and then if it's [feedback] pretty negative then change the practitioner..." (Sue)

"If you've got a practitioner you're not happy with, what do you do about it? I think there ought to be another person you go to and say I'm not happy with this situation." (Chris)

Participants also suggested a weekend service particularly for those at early stages of treatment or dealing with some crisis over the weekend. Three participants suggested that phone calls in-between sessions will also help clients especially at early stages of treatment. They proposed that in such situations, phone calls in-between sessions could offer much needed support and help clients build confidence to start developing healthy and supportive network:

"… I think it would do service users good particularly at the start if there was this [in-between sessions phone calls] follow up, if they were either rung or text, because people are so vulnerable, all the time, but particularly in this, that would be so reassuring for somebody if xxx (the service) could contact them just as a matter of protocol or routine." (Steve)

"… facing this big void of uncertainty and no support at home. If somebody could've just reassured me by calling me." (Emily)

Participants suggested 'follow up' interventions after the non-attendance in order to improve engagement and attendance rate. They discussed a sense of 'void' particularly at early stages of recovery and more proactive follow up after non-attendance could really help clients successfully move through difficult transitional steps at early stages of treatment. Participants also shared the importance of feeling welcomed by the service in order to attend their appointments:

"*You feel that somebody is actually taking an interest in you and your situation whereas you at that time are not in control of the situation but if you feel you're not welcome then you're not going to come, because you're going to use every single excuse you can, I couldn't get the bus, I missed the bus so you turn around and go back." (Sue)*

"… follow up call after your first meeting is really important …" (Emily)

"… you kind of commit to making some changes in your life but there's a sense of void, a gap there, you can't go back to your normal ways of dealing with life using alcohol…. so more support is needed when you first stop drinking…. Everything is different…. everything is unknown… little more help with adjusting with the painful reality of life…" (Chris)

Clients highlighted a range of reasons for clients' non-attendance and made suggestions in relation to improving clients' attendance. These suggestions included; phone contact in-between sessions, on-going independent service and practitioner satisfaction feedback system (Marsden et al., 2000; Kuusisto and Lintonen, 2020), and prompt follow up after DNAs (Booth and Bennett, 2004). In the next section, I will briefly discuss the findings of this strand with more detailed discussion in chapter 8.

7.5 Discussion

This strand set out to explore clients' views about people's non-attendance at a community-based alcohol service and their suggestion to improve clients' attendance. The key aim of this strand was to explore clients' perspectives with regard to clients' non-attendance. The main research questions were: What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service? How do clients make sense of their 'non-attendance' – exploring their thoughts, feelings, interpretations and behaviours? What features do clients suggest may improve their attendance?

Many clients highlighted a range of reasons for clients' non-attendance including client-related and service-related factors. Clients reported that poor emotional and mental

health issues, denial about personal drinking issues and need for support, relapses, and other professional support appointments such as housing, mental health, GP, contribute to clients' non-attendance. The above findings indicate a range of service-related factors that negatively impact client's engagement and attendance such as intrusive assessment process, distance to the agency's site, transport issues, poor therapeutic environment of the agency, and lack of flexibility in practitioner allocation.

In clients' view, it is important for their addiction recovery and treatment engagement that their emotional and mental health needs are addressed appropriately. It is important for the agency to consider developing integrated treatment pathways, that is, addiction treatment and mental health services work together and where possible develop an integrated treatment plan. Clients reported that often they were sent to addiction treatment agencies by the statutory mental health services to address their addiction issues first. This raises a concern about lack of understanding about addiction in mental health sector. Many clients reported that their addiction issues co-existed with their emotional and mental health challenges, such as, anxiety and depression. The current addiction treatment and mental health sectors mainly offer their services in a fragmented manner. A historic argument to determine the cause-and-effect relationship regarding mental health and addiction lead to disjointed treatment experiences for clients. There is a need to offer integrated services to clients where their different issues such as housing, mental health, family, social, and employment are treated as inter-related dynamics impacting the client as a person. Splitting of service provision often requires apportioning the person's experiences and existence in fragmented parts in order to fit clients in the service referral thresholds. The Public Health England issued revised guidelines (Christie, 2017) for the commissioners and service providers in England regarding working with clients with co-occurring mental health and alcohol/drug use conditions. This included a range of co-ordinated approach interventions among different service commissioners and service providers (see Table 7.2 below).

Table 7.2 Public Health England guidelines for commissioners and service providers regarding co-occurring conditions (Christie, 2017: 23)

- this is everyone's job - meeting co-occurring alcohol/drug and mental health needs should be core business for both alcohol, drug and mental health services, supported by wider health and social care services
- commissioners and providers should agree a pathway of care and routinely measured outcomes which will enable collaborative delivery of care by multiple agencies in response to individual need
- every person with co-occurring conditions should have a named care coordinator to help coordinate the multi-agency care plan
- people should be able to access the care they need when they need it and in the setting most suitable to their needs
- there should be a 24/7 response to people experiencing mental health and alcohol and drug use crisis, including intoxicated individuals, with episodes of intoxication being managed safely, and an agreed plan to help people access ongoing care and manage future crisis episodes

The above findings emphasised the significance of the therapeutic environment, privacy, flexibility in choosing preferred practitioner, distance to the agency, and transport issues in relation to clients' engagement and attendance. Several clients stated that poor therapeutic environment made significant impact on their decisions to attend their sessions in the past. For clients, spacious, welcoming, clean, private, discrete, and multipurpose environment contributed to positive therapeutic environment. This raises the challenge of funding and resource gaps for the service providers. In my experience, many addiction services rely on limited funding (Gabbatiss, 2019) and very little resources allocated to building infrastructure in their annual budget. This means that often the service providers are unable to make the space welcoming and appropriately decorate due to lack of resources.

The findings of the clients' focus group reiterated the significance of an effective client-practitioner therapeutic relationship on clients' engagement and attendance at

services. All clients in the focus group stressed that a good therapeutic relationship with their practitioner was the single most important factor that contributed to their decision to engage and attend their treatment sessions. It was importance for clients that their practitioners offer a real 'person-to-person' relationship based on authentic, compassionate, and empathic presence. All the clients who participated in this strand preferred to work with practitioners with personal addiction experiences. For clients, personal addiction experiences greatly supported practitioners' empathic presence. It means that clients felt better understood by those practitioners who had personal addiction experiences compared to those without such personal experiences. In addition, it also highlights policy change implications for the service providers to carefully consider this issue during practitioners' recruitment (Curtis and Eby, 2010). The issue of practitioners' personal addiction experiences, is related to their potential to be empathic. As highlighted above, for clients, feeling heard, seen and appropriately 'received by their practitioner' was the most crucial aspect related to their motivation to engage and attend at treatment sessions. Empathy, the practitioner's ability to understand the client's perspectives including thoughts, emotions and feelings, is considered as the single most important therapist-based relational attitude in the counselling and psychotherapy field (Rogers, 1980; Blatt et al., 1996). This requires an appropriate screening process during practitioners' recruitment that could assess their capacity to be empathic and responsive to relational dynamics.

It is important to understand and support clients who make significant life changes when they first start their treatment. Giving up or cutting down alcohol often leaves people with a sense of 'void' in their lives and only meaningful support from practitioners would make a positive difference. For many clients, addiction becomes the most central part of their lives. Their daily routines revolve around drinking, buying, planning next drinking sessions and dealing with after-effects of their drinking sessions. It is obvious that when clients begin to make changes to their drinking styles, they experience psychologically unsettling phase and often they would relapse and DNA their sessions. It is, therefore, crucial for clients' recovery and engagement that treatment services carefully offer considered and client-centred treatment plans including more regular, consistent, and effective engagement interventions. Many clients also suggested that there should be a robust and consistent system in place to receive and respond to clients' feedback about their experiences of their treatment and practitioners. In addition, clients also

recommended a prompt follow up approach, that is, practitioners should reach-out to their clients promptly after they miss their sessions. These follow up interventions should be offered with sensitivity in order to avoid shaming clients for not turning up and focus on re-engagement strategies (Sheeran et al., 2007; Matthews et al., 2017).

7.6 Chapter summary

In this chapter, I have presented the findings of the clients' focus group. Clients explored a number of reasons for clients' non-attendance including client-related and service-related factors. The findings of this strand concurred with practitioners' views that the client-practitioner working alliance was a significant factor in relation to clients' engagement and attendance. Clients suggested a range of steps to improve clients' attendance such as phone contact in-between sessions particularly at early stages of treatment, service satisfaction feedback system and prompt follow up after DNAs. In the next chapter, I will present the integrated discussion based on all three strands of this research – quantitative, practitioners' interviews, and clients' focus group.

Chapter 8 Discussion

This is the first mixed methods study to explore reasons for clients' non-attendance at a community-based alcohol agency from both the practitioners' and clients' perspectives. It brings together a large dataset of client data and the voices and perspectives of both clients and practitioners at a community-based alcohol agency. The quantitative strand comprised secondary analysis of an existing dataset of 194,679 appointments relating to the attendance of 22,405 clients over a four-year period (Jan 2010-Dec 2013). No previous quantitative study in this area has used such a large dataset. The qualitative strands comprised one to one interviews with practitioners (n=15) and a focus group with clients (n=8). No previous research has focused on the qualitative explorations of clients' non-attendance from both the practitioners' and clients' experiences. Previous research in the area of clients' non-attendance has mainly focused on clients' demographic factors – see literature review (Chapter 2).

The findings of both qualitative and quantitative strands offer a novel and detailed insight into practitioners' and clients' perspectives in relation to clients' non-attendance at a community-based alcohol service. Non-attendance at appointments is a widespread issue within health and social care services and particularly in addiction treatment services. This PhD research has started to fill the gaps in relation to understanding a range of possible factors linked with clients' attendance at their appointments and what can be done to improve clients' attendance.

In this chapter, I will discuss the findings of practitioners' interviews and clients' focus group. In addition, I will incorporate results from the quantitative strand to explore divergent and convergent perspectives within the data, in line with Creswell and Plano Clark's (2011: 212) recommendation that 'mixed methods interpretation involves looking across the quantitative results and the qualitative findings and making an assessment of how the information addresses the mixed methods question in a study'.

8.1 Divergent and convergent findings

The following table (8.1) demonstrates convergent and divergent perspectives of all three data strands: quantitative – secondary data analysis, practitioners' perspectives (interviews), clients' perspectives (focus group).

Table 8.1 Summary of quantitative results and qualitative findings

Factors / Themes	Quantitative Strand (Logistic regression)	Qualitative Strand - Practitioners' perspectives	Qualitative Strand - Clients' perspectives
Age (Younger clients)	✓	✓	X
Ethnicity (BAME)	✓	✓	X
Mulitple needs	X	✓	✓
Employment status	✓	X	X
Accommodation needs	✓	X	X
Parental status	✓	X	X
Discharge reason	✓	X	X
Risk levels	✓	X	X
SMS text message reminder	✓	✓	✓
Time of the session	✓	X	X
Early treatment stage	N/A	✓	✓
Forgetfulness	N/A	✓	✓
<u>Service-related factors:</u> Staffing, funding cuts, limited venues, DNA: A system's need	N/A	✓	✓
<u>Client-related factors:</u> Poor emotional health, denial, relapse, other commitments	N/A	✓	✓
Practitioners' background – personal experiences of addiction	N/A	✓	✓
Practitioner-client relationship	N/A	✓	✓

<u>What can be done to improve attendance?</u> Creative engagement, offering a flexible service, follow up	N/A	✓	✓

In this chapter, I will discuss the findings paying particular attention to those where the data sources converged. As you can see (Table 8.1), two themes emerged from quantitative and qualitative strands (practitioners' interviews) – age and ethnicity; one theme emerged across all three datasets – text message reminders; and nine themes emerged from both practitioners and clients' qualitative data – mulitple needs, early treatment stage, forgetfulness, service-related factors, client-related factors, practitioner-client relationship, practitioners' personal experiences of addiction, and ways to improve clients' attendance.

The following diagram (Figure 8.1) demonstrates the qualitative findings' summary comprising practitioners' and clients' perspectives in relation to clients' non-attendance and shared themes between practitioners and clients.

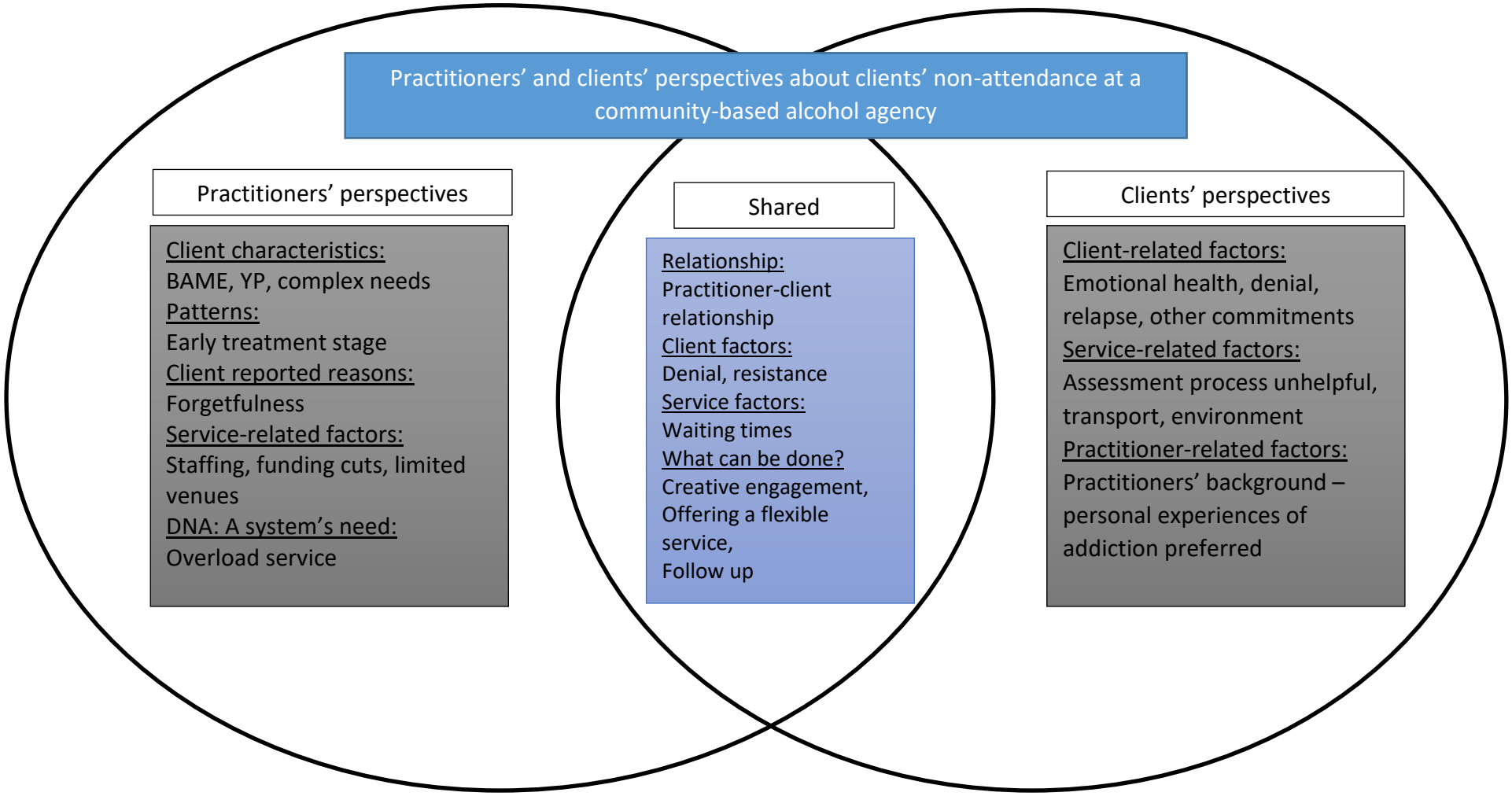


Figure 8.1: Illustrative diagram of the findings from the qualitative data strands

Certain findings of the qualitative strands are consistent with previous research specifically in relation to issues of age, gender, employment, health conditions, forgetfulness and therapeutic relationship. Nonetheless, there are certain key themes highlighted in the qualitative strands that provide innovative and comprehensive information about factors linked with clients' non-attendance. These themes are, for example, DNA – as a system's need, the therapist-client relationship and introducing the original concept of 'co-created-motivation' and practitioner-related factors.

The following discussion will integrate the qualitative findings (both practitioners' and clients' perspectives) with inferences grounded in the quantitative data. It will be based on three areas directly related to the overall research aims; reasons for non-attendance (What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service in the practitioners'/clients' views?); practitioners and clients' perspectives and experiences about non-attendance (How do practitioners view and experience their clients' non-attendance – exploring their (practitioners) thoughts, feelings, interpretations and behaviours?/ How do clients make sense of their 'non-attendance' – exploring their thoughts, feelings, interpretations and behaviours?), and ways to improve clients' attendance (What do practitioners think will improve their clients' attendance?/ What features do clients suggest may improve their attendance?). I will include a comparative and integrated exploration of previous discussion including quantitative results.

8.2 Reasons for non-attendance

8.2.1 Age

Practitioners highlighted younger age, ethnicity and complex health and social needs as common client-related factors linked with non-attendance. Both quantitative and qualitative strands present consistent findings that younger clients were more likely to not attend their appointments. In the practitioners' view, certain attitudinal characteristics of young people such as lack of organisation, care-free attitudes and impulsivity may be linked with missing appointments. It could be argued that additional factors are also linked here

such as, young people not having had problematic substance use for very long, lack of recognition or/and awareness of problematic substance use, lack of life experiences, feelings of invincibility, and extensive use of alcohol deemed normal behaviour with family and friends' context. I was unable to recruit any clients from this age group for the focus group study despite extensive efforts of many months. The QUAN results show that younger clients (18-24) were more likely to not attend their appointments and the DNA rate was 37.8% for 18-24 years old compared to 14% for 65-74 years old group.

Previous research (Siqueland et al. 1998; Booth and Bennett, 2004) supports the current findings that age is an important associated factor in relation to clients' attendance, that is; younger clients are more likely to not attend their appointments. Booth and Bennett (2004) reported younger age associated with non-attendance at an initial appointment at a specialist alcohol treatment clinic in the UK. A large multisite USA based study by Siqueland et al. (1998) explored different predictors of cocaine dependency treatment dropout rates at different phases of clients' engagement. Siqueland et al. (1998) reported that younger age was associated with higher dropout rate at initial appointments and at randomly assigned treatment modalities: supportive-expressive therapy, a particular psychodynamic approach based on the model of Luborsky (1984, as cited in Siqueland et al., 1998), and cognitive therapy (Beck, 1993). Siqueland et al. (1998), a USA based multi-phase quantitative research, studied clients' dropout rates at two stages of treatment pathways, that is, the initial stabilisation phase (n=675) and the treatment phase (randomised sample n = 286). Logistic regression and survival analysis were used for statistical analyses and they concluded that younger clients and clients with other mental health issues predicted treatment dropouts at treatment phase (Siqueland, et al., 1998).

The findings of this study and previous research concur that younger people were more likely to not attend at their treatment sessions. As noted in Chapter 5, only 6% of clients were from 18-24 years' age-range and vast majority of clients were older such as 22% from 25-34, 31% from 35-44, and 26% from 45-54 years' age-range. It could be argued that practitioners were more equipped and accustomed to work with older clients. In practitioners' views, younger clients were: more likely to not take their excessive drinking seriously, be resistant to engaging in treatment in a consistent manner, and in many cases lacked experiential history in the harms of excessive drinking. Older clients were more likely to have had developed alcohol dependence, associated health issues such as liver, kidneys,

stomach issues, social and familial challenges, financial, and housing problems. On the other hand, younger clients were more likely to not have developed serious alcohol-related issues. Younger clients would be more likely to have hazardous drinking style (Ng Fat et al., 2018) (a person is not dependent on alcohol but their excessive drinking could lead to negative consequences) and older clients would be more likely to have developed both psychological and physical dependence (drinkaware, n.d.). These differences between younger and older clients require unique, relevant and responsive interventions in order to meaningfully engage with both groups of clients. For young people, previous studies (Schroder et al., 2009; Alessandrini et al., 2018) recommended specific and age-appropriate interventions such as 'interventions aimed at delaying the age of first contact with alcoholic beverages through the implementation of educational campaigns aimed at younger people, their families and the whole society' (Alessandrini et al., 2018:113). The Public Health England reported that during 2018/19 less than 1% young people required pharmacological interventions during treatment (PHE, 2019). This shows that less than 1% young people experienced alcohol-related physical dependence symptoms that required medical detoxification or physiological withdrawal treatment medication. Dependent alcohol drinking style requires specific, tiered, and multidisciplinary interventions such as psychoeducation, medical detoxification, relapse prevention support including specific post-detoxification medication to prevent further relapses if required, structured psychological interventions, and a range of group-based interventions. Often a range of other professionals such as GPs, psychiatrists, mental health teams, social workers, hospital staff, housing officers, and criminal justice teams also work closely with alcohol practitioners in relation to dependent clients. Whereas, it is more likely that younger clients would require different types of interventions, that is, primarily psychoeducational and informative to meet their needs (Alessandrini et al., 2018). During 2018/19, most young people referrals to addiction services came from education setting (PHE, 2019), therefore, having a specialist addiction workers based within psychoeducation institute would offer a more accessible support to young people.

The above discussion raises potential gaps in the practitioners' skills and competencies to respond effectively to the needs of younger people. It is important that the treatment providers carefully assess gaps in their treatment options and ensure that they offer person-centred interventions instead of 'off the shelf' treatment packages (Schroder et

al., 2007). It is also possible that younger clients would feel they do not fit within an agency that works primarily with older clients. Alcohol treatment agencies would benefit from involving younger clients in the development of specific intervention strategies targeting this age group (Schroder et al., 2009).

8.2.2 Ethnicity

The practitioners' interviews highlighted that the clients' ethnicity is linked with their non-attendance. Black and Asian clients may find it difficult to access and engage with services that mainly run by a majority of white staff. The focus group did not have any Black or Asian clients despite extensive efforts to include clients with minority ethnic backgrounds. This is itself an indication of accessibility challenges faced by many minority ethnic clients. The QUAN strand (chapter 4) covers the discussion in relation to ethnicity in detail. The QUAN results show that Bangladeshi (37.6% DNA) and Pakistani (36.7% DNA) clients were more likely to not attend their appointments compared to White British clients (24.4% DNA). All the clients (focus group) unanimously agreed that their practitioners' race did not impact their attendance. However, it could be argued that race was not considered as an important factor due to a colourblind attitude (Bonilla-Silva, 2013; Zou and Dickter, 2013).

Zou and Dickter (2013), an American study, explored the attitudes of white college students towards a racial minority group member in an imaginary situation. Participants (n=113) were assigned a vignette based on a white character making a prejudiced comment and a black character confronting the comment. Most white students reported that that the black character's response was inappropriately negative. This study supports the notion of prevalence of racial colour blindness among white people (Zou and Dickter, 2013).

It could be argued that in being an all-white client focus group, the issues of 'colour blindness' and fear of being labelled as 'racist' played a role in diminishing the significance of race in the practitioner-client relationship. The notion of white fragility, as DiAngelo (2018) describes, leads to defensiveness and denial about racial differences among white people. During the focus group, in response to the question about racial differences, I experienced an awkward silence followed by prompt responses from majority of the group

members that practitioner – client racial differences had no impact on their attendance and practitioner-client relationship. It seemed as if, the white members did not want to explore this issue any further (Anderson, 2019). An important factor here could be that the researcher's ethnicity (Asian) may have influenced participants' careful approach during the focus group in relation to race-focused discussion. Racial colour-blindness attitudes intrinsically have two facets; one, denial of others' racial differences and second, disowning whiteness (Lewis, 2004).

For practitioners, ethnicity in an important factor that impacts clients' engagement and attendance at treatment appointments. The practitioners' strand highlighted issues such as stigma (Kulesza et al., 2016), distrust, religious restrictions and cultural taboo among Black, Asian and Minority Ethnic (BAME) clients (Zane et al., 2004). It is therefore important to explore and understand the role of religion and cultural dynamics in understanding specific challenges for BAME clients in relation to attending their treatment sessions. Religious expectations and strict rules on one hand can support a health-conscious lifestyle such as complete abstinence (in Islam and Sikhism), but on the other hand, they can also impact a person's capacity to access and engage with available support. This is because a Muslim client may find it very difficult to accept that they have a drinking problem and seek support for their drinking that is strictly forbidden in Islam (Qur'an 2:219). The sense of committing a sin possibly leads to denial both at intrapersonal and at collective level within a community. Sandhu (2009) suggests culturally appropriate substance misuse support interventions are urgently needed to support minority ethnic clients. In the UK, Cochrane and Bal (1990) studied patterns of alcohol drinking among Sikh, Muslim, Hindu and white British men. They reported that immigrant Indian men had higher number of alcohol-related disorders. They recruited 200 men from each group; Sikh, Muslim, Hindu and White British and studies their drinking patterns and alcohol related issues. Immigrant Sikh men (born in India but living in the UK) reported heavier alcohol consumption than other groups. Sikh men also had higher average scores on the Alcohol Problem Scale than other groups (Cochrane and Bal, 1990).

Due to the lack of alcohol focused qualitative studies in relation to ethnicity and clients' attendance or barriers to accessing alcohol services, relevant research work such as mental health is also included in this discussion. Memon et al. (2016) in their qualitative

research which comprised of two focus groups, based on 26 participants (13 men, 13 women; over 18 years old), investigated perceived barriers to accessing mental health services among BME (black and minority ethnic) communities based in Southeast England. Memon et al. (2016) identified a range of factors impacting service users – service providers relationships and linked this with service users' challenges to accessing mental health services, as reported by BME service users. These factors included poor communication between clients and services, poor recognition or inadequate response to mental health needs, power imbalance, cultural naivety, lack of sensitivity and discrimination towards the needs of BME clients, and language barriers (Memon et al., 2016). Szczepura (2005) presents a narrative review based on previous research in relation to issues of accessibility to healthcare for ethnic minority populations in the UK. She states that cultural difference is considered as a key explanation for BME clients to not access health services. Cultural differences that impact BME clients and health services interactions include religious backgrounds, expected role of sex (such as male or female), misdiagnosis, incorrect referrals, family dynamics as well as marketing and information material such as posters and leaflets (Szczepura, 2005).

It could be argued that inherent mistrust among different ethnic minority clients towards service providers is a contributing factor in relation to clients' attendance and engagement. Service providers represent a figure of authority and a voice of 'control' specifically where the ulterior message regarding addiction is very much about 'lack of control'. Being ashamed of one's addiction and feeling 'lesser than the other' could affect White and ethnic minority clients differently as shame and sense of inferiority could trigger deeply disturbing histories of oppression and racism (Thompson-Miller and Feagin, 2007).

This research highlights the issues of historic mistrust and being judged among black clients which is consistent with previous research (Alang, 2019). Alang (2019), a USA-based mixed methods study, undertook secondary analysis of an existing dataset (n=1237) comprised of National Survey on Drug Use and Health data of black adults with unmet mental health needs from 2011 to 2015 and focus groups. Alang (2019) reported that the fear of racial discrimination and stigma was associated with mental ill health among black service users. In addition, 'racism causes mistrust in mental health service systems' (Alang, 2019: 346). The UK-based papers (Owuor and Nake, 2015; Butt et al., 2015) concur with the

issues of mistrust and stigma within BAME clients in relation to seeking mental health support.

To address the issues of mistrust and stigma, it is important that practitioners offer 'embedded relational-racial' interventions. I described this in my recently published paper as, 'the position where a therapist would feel settled in their own skin (literally and metaphorically) in relation to racial differences. They freely engage in the exploration of permanently dynamic aspects of the client-therapist relational space in relation to being white or black. As a therapist, one needs to let go of any desire to resolve racial tensions or suppress one's own whiteness.' (Mahmood, 2020: 78). This could only be possible if practitioners demonstrate enhanced self-awareness of relational dynamics when working with racially different clients. Ryde (2009: 15) suggests some really pertinent questions for white practitioners to consider:

- *Who I am as a white person?*
- *What is the nature of my privilege as a white person?*
- *How does being white affect my ability to relate to people who are not white?*
- *What is the nature of race?*
- *Who am I in a racialized environment?*

It is essential that practitioners are appropriately supported by their employers including offering appropriate training, ongoing clinical supervision and creating an inclusive work environment. It is also important for alcohol treatment agencies to critically review their treatment philosophies and interventions and administrative processes to ensure equitable, inclusive, and responsive service provision to a diverse range of clients. Hakim et al. (2019) reported that providing culturally specific interventions would significant improve BAME clients' treatment engagement and outcomes in emotional and mental health settings.

8.2.3 Clients with multiple needs

Both qualitative strands (practitioners' and clients' perspectives) highlighted that additional complex needs such as mental ill health, housing, and financial issues impact clients' attendance at the agency. Clients reported that engagement with multiple services at the same time negatively impacted their attendance such as two or more appointments

with different professionals on a same day. Clients pointed out a range of factors that negatively impacted their attendance such as denial, social anxiety, feeling low, nervousness, and feeling uncomfortable. Many clients reported that they missed their sessions because they were feeling depressed on the day of their appointments, depressed enough that they were not even able to call their practitioners to cancel their appointments.

It is common that people with long-term alcohol addiction would develop a range of associated issues such as physical and mental health, financial, housing, employment, family and social, and criminal justice (PHE, 2016; NHS, 2018). The journey to recovery requires addressing a number of issues at the same time. Many clients reported feeling overwhelmed by the extent of meetings with different professionals. The finds of this study concur with Coulson et al.'s (2009) research that clients with multiple needs were more likely to not attend their sessions.

The concept of intersectionality has been widely discussed in the last 20 years in relation to clients with a diverse range of needs and individual experiences. Collins and Bilge (2016: 14) describe it as '…intersectionality views categories of race, class, gender, sexually, class, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another'.

The findings of this study highlight that clients with multiple needs would more likely to not attend their sessions. Therefore, it is important that practitioners demonstrate enhanced self and relational-awareness about issues of intersectionality and marginalisation, that is, clients' diverse intrapersonal, interpersonal and societal experiences impact different clients differently. It requires practitioners to avoid using 'one size fit all' approach whilst dealing with complex human conditions. In order to improve the attendance of clients with multiple needs, it is crucial that practitioners appropriately assess their clients' needs and work collaboratively with them in order to offer meaningful client-centred treatment plans and interventions. In addition, the treatment agencies must work in true partnership to avoid several parallel treatment or engagement journeys. For example, a client with alcohol dependence issues and associated problems such as housing, unemployment, mental ill health (depression), physical health issues (liver damage), and family issues would be expected to work with at least eight different agencies and possibly more professionals. Public Health England recommended a multi-agency, coordinated and

collaborative approach to working with clients with alcohol and mental health issues in order to achieve greater treatment accessibility and effective recovery-oriented outcomes (Christie, 2017).

In the next section, I will explore clients' patterns in relation to their non-attendance and particularly explore four areas; early recovery stages, forgetfulness, and assessment processes.

8.3 Clients' patterns

8.3.1 Early recovery stages

Both qualitative strands draw attention to higher DNA rates at the early stages of treatment. Practitioners suggest that many clients would miss their appointment during 'contemplative' phase (Prochaska and DiClemente, 1983), that is, when they are still considering any behavioural changes. Clients stated 'denial' at early treatment stages negatively impacted their attendance. West and Brown (2013) highlight the significance of the link between theoretical explanation and treatment interventions. Motivational interviewing (Miller and Rollnick, 2013) based interventions can be particularly effective to addressing this early resistance in addiction treatment (Gilder, et al., 2017). Gilder et al. (2017), in their pilot randomised control trial comparing motivational interviewing to psycho-education for reducing alcohol consumption, report both psycho-education and motivational interviewing-based interventions were effective. Appropriate psychoeducation-based interventions would be best suited to address the issues of denial and contemplation (Gur et al., 2017) because denial of harms of excessive drinking could be addressed by highlighting evidence-based information (Yeh et al., 2017).

It is also important that practitioners focus on developing therapeutic engagement interventions at the beginning stages of treatment – see below section 8.4 for further discussion regarding service performance-focused processes and client-focused interventions. It is important that practitioners demonstrate greater awareness of clients' experiences of starting their treatment that often includes life-changing steps, changes in social contacts – in many cases breaking contacts with close friends, embracing emotional vulnerability, and dealing with extreme physical and psychological cravings. It is, therefore,

crucial that practitioners offer greater support to their clients to deal with enormous challenges of their life-changing journeys. In addition, it is important to consider the impact of physical environment of the treatment setting in relation to clients' early treatment stages. The findings of practitioners' and clients' data also highlighted that it was important for clients' engagement that the agency offered suitable therapeutic environment. For clients, a welcoming, relaxed and homely environment is linked to feeling safe and comfortable in the counselling room and therapeutic encounter (Sanders and Lehman, 2019).

8.3.2 Forgetfulness

Both qualitative studies highlight clients' forgetfulness as one of the most commonly reported reason for their non-attendance at appointments. All practitioners instantly reported this when being asked about client reported DNA reasons. Clients also unanimously agreed in their focus group that forgetting their appointments has been one of the common reasons for their non-attendance. Many clients reported inconsistent practices in relation to getting SMS reminders (text messages) i.e. sometimes getting the reminder messages and at other times not receiving any reminder messages. The previous research body strongly supports the hypothesis that receiving text message reminders increase clients' attendance at health service appointments (Perron et al. 2013; Gurol-Urganci et al, 2013; McLean et al. 2016; Robotham et al., 2016; Tofighi et al., 2017). On the contrary, in this research the logistic regression analysis shows receiving text message reminders predict non-attendance. This anomaly was due to the organisational policy during 2010-2013 that SMS text message reminder were sent to only those clients who missed their appointment sessions and therefore the quantitative strand results show sending SMS text message reminders predictors of clients' non-attendance.

Gurol-Urganci et al. (2013) published the Cochrane review based on randomised controlled trials assessing text message reminders for healthcare appointments. They reported that the use of text message reminders increased patients' attendance rate. According to Ofcom (2019) smart phone usage increased from 17% in 2008 to 78% in 2018. Muench et al. (2013) proposed a theory driven text messaging intervention for continuing addiction support. They reported that '98% of their participants were potentially interested in using text messaging as a continuing care strategy' (Muench et al., 2013: 315). Milward et

al. (2014: 625) conducted a narrative review and suggested that 'multi-component text message intervention incorporating different delivery and content strategies' could be used to improve clients' attendance at substance abuse services.

It could be argued that forgetfulness is a defence mechanism against shame associated with alcohol addiction and non-attendance. Matthews et al., (2017) state that many clients with addiction issues internalise several external negative stereotypes and stigmatisation. It could be argued that external negative stigmatisation (Cunningham et al., 1993) leads to internalised shaming. Robine (2013) describes shame as a relational process with twofold implications; one, it negatively impacts personal identity and the other, it breaks the connections with others.

Shame is one of the basic human emotional experiences. Robine (2013) states that shame is associated with our sense of being, how we are received, perceived, acknowledged and judged by others. "It relates to lived experiences of indignity, weakness impotence, inadequacy, dependence, fragility, and incoherence beneath the gaze of another: the feeling that – as I am, I am not worthy of belonging to the human community" (Robine, 2013). Shame is a relational concept; it is about how we relate to others and vice versa. I would suggest that it is important to explore the concept of non-attendance from a relational perspective. Negative perceptions about addiction are bound to impact how clients feel about their addiction and about seeking help. Non-attendance can be a shaming process for a client. The very essence of 'shame' is to withdraw, hide, disappear, or reduce contact (Gordon, 1994).

For Wheeler (1997), shame is 'one of the most potentially disorganizing of all affect experiences' (p. 221). Inherently, shame is a relational phenomenon. It is related to how we have been received, accepted and recognised by others. 'It relates to lived experiences of indignity, weakness, impotence, inadequacy, dependence, fragility, and incoherence beneath the gaze of another: the feeling that, "As I am, I am not worthy of belonging to the human community" (Robine, 2013). It could be argued that clients from the place of self-stigmatisation or shame would find it very difficult to attend their sessions particularly if they had lapsed/relapsed since their last meeting. This lens could be used to understand

clients' non-attendance at their appointment to avoid further shaming in relation to relapses.

Health services or addiction treatment sectors are possibly seen by many clients as the representatives of power and authority. Different addiction theories, techniques, tools and performance-based treatment models are all mainly service-focused or service-driven. The very notion of non-attendance is based on not fulfilling the psychological contractual agreement of attending a session. This inability indeed can be very shaming. If there is no outpatient appointment system in an addiction service, then there will not be any DNA. Could there be a different kind of contract between a client and their practitioner which is not based on a medical outpatient clinic template? Could services consider offering a 'drop in' service at the early stages of contact? Could there be a phase between the referral and the registration stages of service delivery to clients such as 'pre-registration' phase where clients can access services without 'having to' attend appointments.

Clients' forgetfulness could also be linked to how they value the service. Perceived free health and addiction services inherently have advantages and disadvantages in relation to their effectiveness. Whilst the UK-based health and addiction services are perceived to be free, because no financial transactions occur at the point of access, they are not free of cost indeed and require huge tax payer funds to set up and maintain. The health and social care budget for 2020/21 was £149.8 billion for 2020/21 and additional £50 billion for Covid-19 pandemic response for 2020/21 (Kingsfund, 2020). Most addiction services across the UK are available to clients without any appointment cost although the costs of travelling remain a challenge for many people. Many addiction services endeavour to offer flexible appointments to their clients. Nonetheless, despite offering such facilities paradoxically the support/treatment available has been 'devalued' because in some cases it is available without much effort on service users' part (Akter et al., 2014). There is no previous research study found that compared the impact on free versus paid addiction treatment on clients' engagement and treatment completion.

It could be argued that 'free NHS' and 'free addiction support' in the UK has led to shift of paradigm at the personal level for some people in relation to personal responsibility towards their own health and sobriety. This could lead to internal dissociation from their

issues (addiction) and attending appointments may be experienced as 'this is something I need to do for my practitioner'. The results of the quantitative strand show that evening appointments (after 5pm) are well attended compared to some day time appointments. To get an evening appointment clients were required to wait for the next available slot due to a waiting list and stricter attendance policy was used, that is, clients were strongly encouraged not to DNA due to limited availability and clients would lose their slot after two DNAs.

In this section, I have discussed a range of factors linked to clients' forgetfulness such as, shame, perceived value of the service, impact of excessive drinking on memory, chaotic lifestyle and drunkenness. The value of using text message reminders is well established and addiction treatment agencies must ensure that they send automatic text message reminders to their clients. In the next section, I will discuss the clients' assessment process and its impact on clients' engagement and attendance.

8.4 DNA – a system's need

The findings of this research suggest that DNA could be seen as a system's need. The theory being proposed (Chapter 9) is that services can only cope with a certain number of clients and without inbuilt unintentional DNA percentages, the service will be unable to function effectively. Practitioners highlighted a range of issues related to funding cuts; increased caseloads, poor service accessibility, limited staff, lack of venues, limited evening and weekend service, lack of specialist staff, high waiting times, staff burnout (Ewer et al., 2015), increased staff turnover and limited support intervention menu. Under such working conditions, it would be extremely difficult for practitioners to be able to see all their booked clients, step in to support other service needs such as cover for staff shortage, deal with unexpected clients related crisis such as; suicidal ideation or safeguarding, and as well as keep up with their clinical notes and client records. It is understandable that the organisation relied on a certain DNA percentage in order to cope with extensive demand and pressure.

However, such a strategy was not only short-lived but also contributed to the already unsustainable workload for practitioners. Where practitioners welcomed clients' DNA in certain situations, they were also required to follow up their clients who missed their

sessions. Depending on clients' additional complex needs, practitioners were required to also liaise with other professionals such as GPs, housing officers, social workers, and mental health crisis teams. This additional administrative work added even further pressure on practitioners.

Addiction services in the UK have faced contrasting financial situations over the last 20 years. During the New Labour government (1997-2010), extensive investment was made in the addiction treatment field (Buchanan, 2010). Significant policy changes in 2010 shaped the current addiction service provision in this country. These changes included; the policy change – an introduction of one drug strategy 2010 (gov.uk, 2010) instead of separate alcohol and drug strategies, service commissioning moved from central government to local governments, funding cuts (Harries, 2011), and a payment-by-result approach (Roy and Buchanan, 2016). Alcohol-specific service providers were adversely impacted by the 2010 drug strategy because of the removal of ring-fenced funding availability for alcohol service provision by local commissioners. This led to a reduction in alcohol treatment provision due to austerity measures and pressure on regional commissioners to show efficiency (Buykx, 2020).

The issues of austerity, funding cuts, and staff burnout are interlinked. The current period of financial austerity has negatively impacted a wide range of services including substance misuse treatment provision (Roy and Buchanan, 2016). The service providers are expected to deliver more with less staff and of course this has significantly increased the workload of many frontline staff. A practitioner's conscious or unconscious desire for his/her client to not attend a particular session so that he/she can complete other pressing tasks could be seen as, what Joyce and Sills (2018) explain as, a creative adjustment.

The issues of compassion fatigue or burnout (Sprang et al., 2007) are widely written about in relation to social worker and specialist trauma workers (Pearlman and Saakvite, 1995; Huggard, 2017), however limited attention has been given in relation to substance misuse worker (Johansen et al., 2019). Many addiction practitioners work with and are exposed to a range of clients with diverse associated issues such as, emotional, physical and sexual abuse, trauma, and loss (Fahy, 2007; Perkins and Sprang, 2013). It could be argued

that, like vicarious traumatisation, vicarious apathy impacts addiction practitioners and it would be useful to undertake an empirical study to explore this notion further.

8.5 Client-practitioner working alliance: Impact of practitioners' personal addiction experiences

Both qualitative strands identify the significance of practitioner-client relationship in relation to clients' attendance at their appointments. All of the clients in the focus group strand suggested that they would prefer working with practitioners who had personal experiences of living with addiction. There was a divided view among practitioners; some supporting the idea that practitioner's personal addiction histories enhanced the potential of empathic attunement. On the other hand, some practitioners shared that it is neither possible nor required to have personal lived experiences of all kinds of issues that clients may present. Some treatment providers, particularly those based on a 12 step model and the Minnesota Model (Anderson et al., 1999), recruit staff with personal history of addiction, however, this is not a standard practice across alcohol service providers in the UK. The Minnesota Model treatment workforce model is based on multidisciplinary staff team including professionals and trained recovering counsellors (Anderson et al., 1999).

Stoffelmayr et al. (1999) reported recovering counsellors (counsellors with personal history of addiction) offered a wider range of treatment practices and treatment goals compared to professionally trained addiction counsellors. Curtis and Eby (2010), a USA-based qualitative study, collected data from 86 addiction treatment organisations across the USA and considered 695 addiction counsellors for their study, analysed by multiple regression analyses. Average caseload of each counsellor was approximately 25 clients and 38 percent counsellors were personally in recovery (Curtis and Eby, 2010). They suggest that counsellors in recovery would report higher professional commitment in their jobs as addiction counsellors compared to addiction counsellors who were not in recovery (Curtis and Eby, 2010). Lawson (1982), in a North American quantitative study based on 28 counsellors' traits, suggested that clients perceived counsellors in recovery as more effective than counsellors not in recovery, that is, with no personal addiction experiences.

On the contrary, Toriello and Strohmer (2004) highlighted that 'group membership similarity', that is, counsellors with personal addiction experiences, had no significant

impact on clients' experiences of counsellor credibility and trustworthiness. They recruited 116 individuals (90 females, 26 males; 60% White American, 37% African American) receiving addiction treatment in the greater New Orleans, USA, and they used multivariate analysis of variance and hierarchical multiple regression for their data analysis (Toriello and Strohmer, 2004). A systematic review on peer-delivered recovery support for addictions in the USA by Bassuk et al. (2016) comprised nine studies and demonstrated that the majority of previous research suggested that peer led recovery-based interventions had a positive impact on addiction treatment outcomes.

It is a growing trend in the addiction treatment field in the UK to recruit practitioners in recovery, however this has been going on since 1940s in the USA (Doukas and Cullen, 2010). On the one hand, recruiting practitioners in recovery has many benefits such as empathic attunement, but on the other hand this practice presents a range of challenges. Doukas and Cullen (2010), in their review paper, summarise a range of challenges in relation to perceived potential risks regarding practitioners in recovery such as; 'personal help from self-help groups may be lost once in the field, over involvement with clients, over involvement with work, over identification with clients and the repercussions of relapse' (p. 216). Practitioners in recovery or those that have close contact with people in recovery are also likely to develop compassion fatigue (Perkins and Sprang, 2013; Gerard, 2017). Perkins and Sprang (2013), a USA based qualitative study, comprised individual interviews with 20 substance abuse counsellors. Participants were encouraged to explore any unique challenges and compassion fatigues in relation to working as substance misuse counsellors. They reported two key themes; working with women was reported as being more challenging work experience, and counsellors were more susceptible to compassion fatigue if they had personal experiences of addiction (Perkins and Sprang, 2013).

The focus group (clients' perspectives) findings suggested that the client-practitioner therapeutic relationship is crucial for their engagement and recovery. As discussed in the literature review (Chapter 2), an extensive research body available that supports the significance of client-practitioner relationship in relation to clients' treatment engagement and outcomes. Clients, who participated in this study, preferred to work with practitioners who were competent in offering compassionate support and appropriate challenges. All clients in the focus group preferred to work with practitioners in recovery because they felt

practitioners in recovery offered greater empathic presence. Practitioners' lived experiences of addiction helped them to offer greater relational depth to their clients (Mearns and Cooper, 2018). Empathic attunement (Finlay, 2016) was considered an essential factor that positively impacts client-practitioner relationship. Clients made some suggestions for further improvement in the service delivery linked with their attendance such as, anonymous feedback about their experience after the first session, in-between session phone support, prompt follow ups and out of hours' services.

Practitioners' empathic presence is significantly related to positive treatment outcomes (Elliot et al., 2011). Rogers (1959: 210-11) defines empathy as, 'to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the "as if" condition'. Rogers (1959: 211) stressed the significance of the 'as if' state because losing such a position would lead to over-identification with the client. Elliot at al. (2019) explain empathy as an interpersonal and unidirectional process that is, provided by a practitioner to a client. They further state that empathic interventions include 'understanding the other person's feelings, perspectives, experiences, or motivations' (Elliot et al., 2019: 246). The relevance and importance of empathic presence is not without academic challenges. Bloom (2016) claims in his book that empathy has a potentially negative effect on interpersonal relationships. He asserts that our empathic attitude is inherently biased towards the people we find attractive or who seem similar to us and therefore, we lack empathy towards people who are different or distant (Bloom, 2016). However, there is no published research to test Bloom's (2016) hypothesis. An empirical study to test the validity of Bloom's (2016) theory is needed to aid our understanding about what factors impact practitioners' empathic presence. Regardless of Bloom's (2016) caution about empathy, an extensive research body supports the notion of significance of empathy in client-practitioner therapeutic engagement and positive treatment outcomes.

The assessment session is generally the first meeting between a practitioner and client and it sets the scene for the future of their working alliance. The focus group with clients highlighted the prevalence of uncomfortable initial assessment experiences reported by clients. Clients felt as if they were being interrogated and reported feeling ashamed during this process. Assessment processes included asking personal and sensitive questions

such as history of physical and mental health, medication, offending history, history of domestic violence, suicidal ideations, history of violence, number of children, involvement of social services or safeguarding agencies, names of children's schools, drinking/drugs history, and addiction treatment history including patterns of lapses/relapses. If such sensitive questions are being asked in a robotic or tick box manner it could lead to therapeutic relational rupture potentially resulting in clients' non-attendance. Galvani (2012) cautions about how practitioners' approach the assessment process and highlights the risks of further shaming and stigmatisation. Non-attendance could be seen as a message of dissatisfaction from the client to the service/practitioner.

Dawood and Done (2020) conducted an interpretative phenomenological analysis qualitative study in the UK comprising semi-structured interviews with 11 participants about their experiences of being in recovery. Their research aims were to explore participants' experiences of receiving psychosocial interventions and responding to treatment through drug reduction. They reported five overarching themes; an individualised or client-centred intervention that incorporates skills-based work focusing on life without substance, effective practitioner-client therapeutic relationship embedded in trust and safety, practitioners' ability to be empathic to clients' individual experiences, understanding complex dynamics of clients motivation to change, and families, friends and social support network are crucial to clients' recovery and long term abstinence (Dawood and Done, 2020). This research reiterates previous studies' findings that the therapeutic relationship, empathic presence, individualised client-centred interventions and significance of families and friends for long term recovery are crucial and fundamental therapeutic requirements

8.6 How to improve clients' attendance?

Both qualitative strands highlighted a range of suggestions in order to improve clients' attendance including creative engagement processes, service flexibility and additional funding resources. Practitioners suggested a range of innovative steps (creative engagement and flexibility) such as; phone contact in-between sessions, use of volunteers and peer support to strengthen the workforce, drop ins sessions, improving assessment processes, using community venues, using evidence based treatment models such as Social Behaviour and Network Therapy, and making the service building more welcoming. The focus group study with clients highlighted that it is often very anxiety provoking experience

for many clients to initially contact treatment support services. Going through the initial assessment process was seen as an intrusive and overwhelming experience for many clients. This raises an important issue for the service providers and practitioners about their assessment procedures.

Based on the emergent themes from this research and the wider evidence base, there are three interlinked issues in relation to assessment procedures; 1) the current treatment registration processes lack flexibility, that is, clients cannot commence their treatment until the assessment process is completed and any urgency to address clients' needs puts an additional pressure on practitioners to complete the assessment process hastily, 2) agencies' hyper-vigilant attitude towards potential risk factors and therefore, assessment process is considered as an essential treatment entry requirement, 3) addiction treatment agencies have contractual performance targets including number of clients in treatment and agencies are often under pressure to focus on output-based performance targets. In light of the findings of this study and the wider research evidence, treatment agencies need to focus on client-focused treatment journey instead of output-focused targets. This means introducing additional steps in clients' treatment pathways particularly at the early stages to focus on developing client-practitioner working alliance and client engagement. It seems like that clients have to pay a certain emotional price in order to access any support, that is, clients are required to disclose about their past experiences of trauma, abuse, addiction, previous treatment failures, relapses, criminal justice issues, mental and physical health details, child and adult safeguarding issues including date of births of their children, names of their schools and their care arrangements whilst clients are using substance/s. Based on this research, I propose that agencies should focus on developing client-practitioner therapeutic engagement and personal data collection processes should be handled in a sensitive manner. It requires a paradigm shift from 'assessment as an event' to 'assessment as a process' (Bager-Charleson and Rijn, 2011) and this change is dependent on all stakeholder in service provision such as commissioners, senior management and practitioners' commitment to offer more relational, creative, dynamic and client-focused services. In my opinion, clients should be registered after a brief screening process and any detailed assessment process should wait till a first few sessions with their practitioners focusing on treatment engagement interventions. These initial

sessions should focus on developing rapport and supporting clients to feel welcome and supported in their life-changing recovery journeys.

Both groups, practitioners and clients, recommended greater flexibility regarding practitioner-client contact in order to enhance clients' overall experience of the treatment service and specifically their attendance rate. Offering flexible appointments (easily changeable), use of phone-based interventions (instead of face to face), considering clients' needs during practitioner allocation process and paying attention to practitioner-client matching issues were all suggested. Telephone or video-based online sessions are still under-used in the field as face to face meetings are considered a mainstream therapeutic working arrangement. Whereas, more regular phone-based or online video sessions would easily resolve many issues such as cost of travelling, appointment timings, and distance from the service. Due to the current COVID-19 pandemic, most counselling and addiction support services commenced offering remote (phone or online) sessions since 23rd March 2020 (Gov.UK, 2020). According to the World Health Organisation the COVID-19 pandemic posed serious challenges for social care and mental health service providers worldwide (WHO, 2020). In addition, it also required practitioners to adjust to work differently, that is, transition from face-to-face sessions to remote sessions (BACP, 2019). A research study will be useful to explore the experiences of alcohol practitioners and clients regarding treatment during the current pandemic situation and the impact of online sessions on clients' attendance and overall treatment outcomes.

Lack of planning, memory issues, chaotic lifestyles and being impulsive are some of the common issues with alcohol addiction (Sparr et al., 1993; Moeller et al., 2001; Gudjonsson et al., 2004; Patkar et al., 2004), and so using any interventions to remind clients near the time of their appointments could enhance attendance rate. Text message appointment reminders improve clients' attendance at alcohol outpatient clinics (Hasvold and Wootton, 2011; Gullo et al., 2018). A meta-analysis of 18 studies by Guy et al. (2012) demonstrated a 50% increase in attendance when patients were sent text messages about their upcoming appointment regardless of the type of health service or what time the message was sent. Appointment prompts in order to enhance clients' attendance ware also supported by a UK study (Jackson et al., 2009). Jackson et al (2009) reported the impact of telephone prompting on alcohol clients' (n=172) attendance at a specialist outpatient

alcohol clinic. They used ABAB research design where clients were subject to alternating conditions, that is, with or without receiving a phone prompt a day before their appointment. An ABAB research design has four phases and in each phase participants experience repeated measures of introduction or withdrawn of an intervention to assess its impact (Kirk, 2017). In Jackson et al.'s (2009) study the prompted group (received telephone call reminders) and no-prompted group (not received telephone reminders) were independent. They reported that the clients who were prompted by a phone call reminder were more likely to start and attend their treatment sessions (Jackson, et al., 2009). Practitioners suggested prompt follow up after the DNA would improve clients' future attendance. Clients also supported this idea particularly at the initial stages of recovery where many people would feel overwhelmed by starting their treatment journey.

8.7 Chapter summary

In this chapter, I discussed the findings of two qualitative strands; practitioners' perspectives and clients' perspectives and incorporated results of the quantitative strand. The findings of this research demonstrate that to improve younger clients and BAME clients' attendance, it is important that service providers offer client-centred treatment plans including age-appropriate and culturally sensitive interventions. The practitioner-client working alliance is crucial to treatment engagement, recovery and clients' attendance. For clients, practitioners' personal addiction experiences were a vital factor that supported empathic attunement, offered enhanced trust in their working alliance with practitioners and positively impacted clients' attendance. Lack of appropriate funding led to significant challenges for this agency and the frontline workforce including insufficient service provision, staff shortage, increased workload, job burnout, lack of appropriate venues, and poor client experiences. Consequently, the agency relied on a certain percentage of clients' no-attendance to survive. The practitioners used their clients' non-attendance time to deal with many pressing issues and outstanding tasks such as writing a social service report, data entry, service performance paperwork, dealing with urgent client issues, and offering cover for absent colleagues. Both practitioners and clients suggested a range of steps in order to improve clients' attendance at appointments. These included; SMS text message reminders, follow up phone calls, more regular contact during the early stages of treatment, a flexible appointment system, and creative engagement methods such as phone sessions, home

visits, community outreach service, and use of peer support. The findings of the qualitative strands led to the emergence of a novel working model – co-created motivation. I will discuss this concept in detail in the next chapter.

Chapter 9 Development of a Working Model: Co-created Motivation

This chapter presents an innovative and pioneering working model of 'co-created motivation' – a relational model of motivation. It builds on existing understandings of motivation to change in relation to addiction and is grounded in the key findings of this research. The working model of co-created motivation emerged from this research's aim to better understand the factors that impact clients' attendance at a community-based alcohol service. As noted in the literature review (Chapter 2) there is a crucial omission in the existing literature in relation to explaining what really happens between clients booking a session and not attending a booked session or attending one session and missing another. The existing research mainly attribute clients' non-attendance to either client-related or service-related factors but fail to acknowledge complex relational dynamics between practitioners and clients. This study presents a novel approach to conceptualise the dynamic practitioner-client interaction and its impact on clients' engagement and attendance. In this chapter, I will introduce the concept of co-created motivation, motivation and addiction, and client and staff motivation.

The idea of co-created motivation is based on the findings of this research and is informed by the integration of Gestalt therapy theory (Perls et al., 1951) and addiction theories such as Prime Theory (West and Brown, 2013) and Motivational Interviewing (Miller and Rollnick, 2013). The Gestalt therapy theory is grounded in the post-Cartesian philosophy that rejects the notion of dualism (person-world two separate entities). Both the Prime Theory and Motivational Interviewing concepts will be discussed later in this chapter.

Many practitioners in this study named clients' motivation as one of the key reasons for their drinking and non-attendance at their appointments. On the other hand, clients in the focus group strand named practitioner-related factors such as their motivation as one of the key contributing factors in their engagement.

Co-created motivation refers to interacting forces between a practitioner and client in a counselling room. Practitioners and clients proactively, and mostly unconsciously, impact each other and are impacted by each other (Wollants, 2012). This practitioner-client contact is a dynamic and relational process; dynamic because it is constantly evolving and

relational because it is interdependent. Seeing contact in this way makes traditional views, where a client's motivation to drink or stop drinking is understood as solely their responsibility, redundant. The findings of this research have demonstrated the relevance and significance of co-created experiences between a practitioner and client in relation to clients' engagement. The participants (clients and practitioners) in the qualitative strands highlighted how an effective practitioner-client relationship is key to clients' engagement with the service and to their attendance. This therapeutic effectiveness is dependent on the quality of the working or therapeutic alliance between two parties. The practitioner-client working alliance (Horvath, 2018) is further enhanced through a dialogical encounter, this is what Clarkson (2003) defines as a real relationship. A Gestalt therapy theory concept of dialogical encounter is based on Buber's (1970) notion of 'I-Thou' (Adame and Leitner, 2011). For Buber (1970), there is no 'I' without the other, that is, 'I' cannot exist in isolation. A person can only be experienced, understood, or studied as a part of his/her field and in relation to others. For Yontef (1993), 'all reality is relating'. In order to diagnose a problem with a struggling plant and to recommend a solution, a gardener has to consider not only the plant itself but many environmental factors such as light, location, water supply, quality of soil, fertilisers, neighbouring plants or trees, weather suitability, and many other environmental factors. Similarly, humans do not and cannot exist in isolation. The 'organism-environment field' (Perls et al., 1951) must provide a theoretical basis for any psychopathological assessment and for treatment planning for human conditions such as addiction, depression, anxiety, and relationship problems.

The development of this concept of co-created motivation is influenced by Gestalt therapy theory (Wollants, 2012), that is, individuals do not and cannot exist in isolation or be completely independent from their environment. Wollants (2012), a Gestalt therapy theory author, presents the interactional person-world whole model on the basis of Perls et al. (1951) work. 'Only the interplay of organism and environment… constitutes the psychological situation, not the organism and the environment separately' (Perls et al., 1951: xii). This concept offers a revolutionary perspective to ontological and epistemological lenses to human behaviour. What impacts a person's behaviour, such as addiction or non-attendance, can only be understood and examined in relation to their environmental/ relational conditions. In this interaction, between a person and their world, a person is

neither passive nor reactive. A person proactively influences their environment and responds to environmental conditions (Parlett, 2005). Lewin (1952) suggests that the person and their environment have to be considered as a unified system of different interconnected factors. These are a few examples of different authors who recognised the interaction between a person and their environment as dynamically interlinked. The following diagram (Figure 9.1) illustrates the notion of co-created motivation.

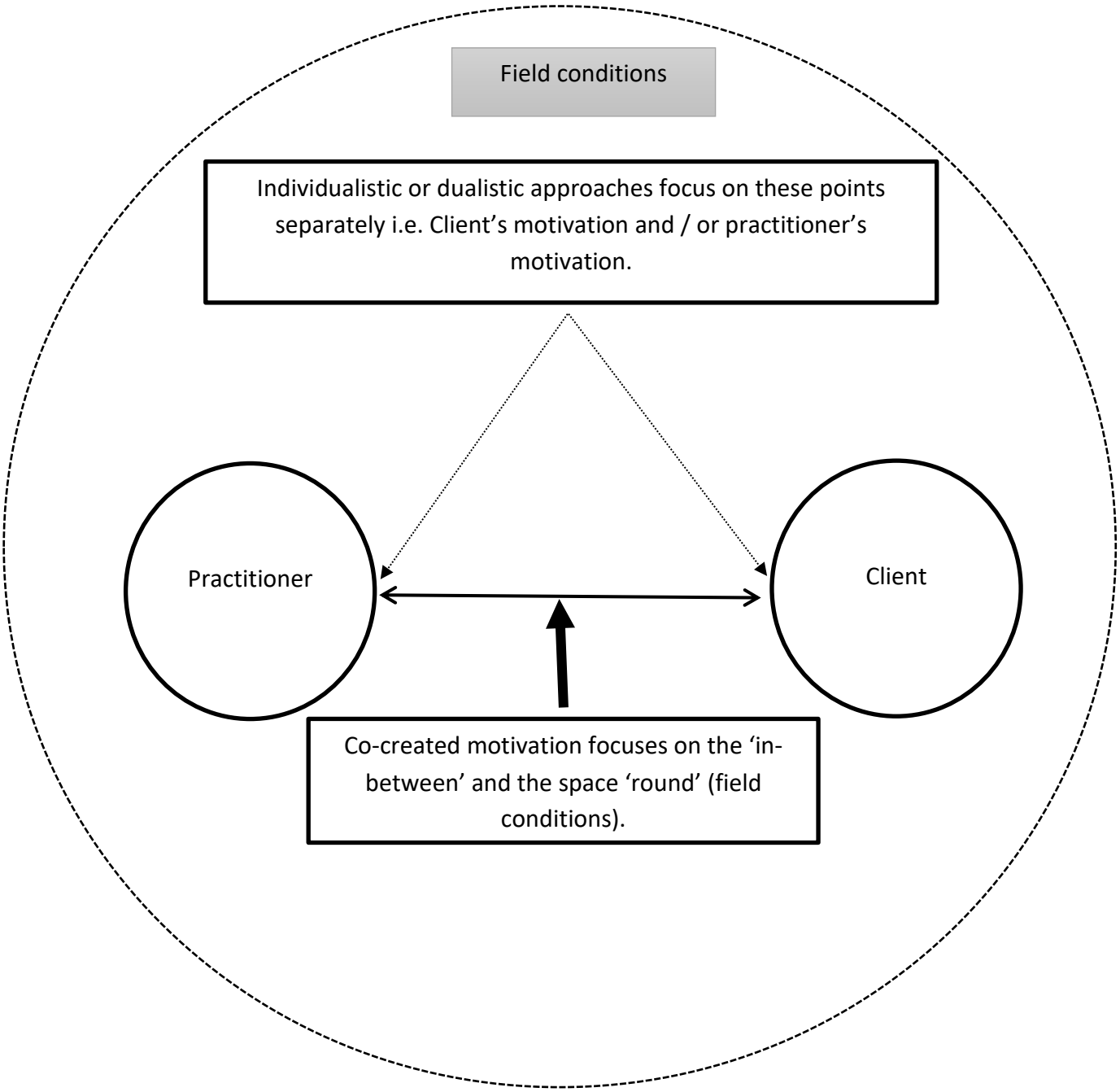


Figure 9.1: Illustration of co-created motivation

The above diagram (Figure 9.1) illustrates the difference between traditional individualistic or dualistic person-world view and 'co-created' motivation. It is based on relational and unified person-world viewpoint. A client influences and is influenced by their practitioner and field conditions. I prefer to use the term field conditions instead of environment (I have used both terms interchangeably in this chapter) because the word environment appears restrictive to immediate physical space of a person. The term 'field' covers both immediately present and historic physical and psychological factors (Parlett, 1994). The field conditions include a range of factors such as physical environment (space in the treatment centre – privacy, welcoming), administrative processes at an agency (waiting times, session booking system), referral processes, physical and mental health issues, social and family context, history of emotional, physical and sexual abuse, trauma including intergenerational trauma history, bereavement, and drinking and treatment history.

In this study, the clients reported that the agency's environment and location contributed to their attendance rates. They said that welcoming, confidential and friendly environment positively impacted their attendance and engagement with the agency. Both practitioners and clients talked about the importance of the venue accessibility and transport challenges in relation to clients' attendance. Clients were more likely to attend if the travelling distance to the agency was shorter and easy public transport routes available. For clients, privacy, confidentiality and discrete building entrance were also important issues in relation to feeling comfortable about attending their sessions. The practitioner-client relational field includes all such factors that could possibly impact each party. It is important to note that field conditions impact clients and practitioners differently, depending on each individual wider field influences. I have illustrated immediate and wider field conditions in Figure 9.2 that could potentially impact clients and practitioners. Each individual (client and practitioner) is impacted by their historic field conditions and when they meet with another human being in a therapeutic encounter they not only respond to their historic but also immediate field conditions. It is important that practitioners have an awareness and willingness to work with co-created relational dynamics in the therapy room in order to improve clients' engagement and attendance. As several clients mentioned (Chapter 7), some practitioners 'don't get it'; I believe this is in situations where practitioners fail to appropriately respond to therapeutic field conditions, leaving clients feeling unheard and

unseen. Clients' non-attendance at their next sessions could understandably be the expected outcome in these situations.

In sum, the findings of this study highlighted a range of field conditions that impact practitioner-client relationship and clients' attendance at their sessions. It ranges from intra-psychic factors such as history of addiction, physical and mental health issues; inter-personal factors such as relational patterns, family dynamics; and treatment contextual issues such as, referral pathways, previous treatment history, short-term versus long-term treatment routes, and types of treatment interventions available.

Most addiction treatment models are based on Western concepts of an individualistic worldview. Medical treatment models focus on individuals and their presenting symptoms. Addiction treatment models also mainly focus on clients' motivation to engage in an addictive behaviour as well as their motivation to access and engage with treatment services. A client's readiness to change is considered as solely a client's issue. An American-based Treatment Improvement Protocols - TIP (Centre for Substance Abuse Treatment, n.d.) highlighted five dimensions of client motivation – 'self-efficacy, readiness to change, decisional balancing, motivations for using substances and goals and values.' Motivational Interviewing (Millar and Rollnick, 2013) shares similar understandings of human motivation to achieve meaningful behaviour changes. I have discussed PRIME theory in Chapter 2 and argued that PRIME theory (West and Brown, 2013) primarily explains addiction as an individual's issue. As discussed in Chapter 3, different theoretical lenses offer diverse perspectives on addiction ranging from biological explanations to social learning perspectives. The existing theories view addiction primarily as an individual's problem, however, the working modelof co-created motivation views addiction as an individual response to their field conditions. In the next section, I will discuss Motivation Interviewing and practitioners' motivation in light of compassion fatigue. This will explore separate motivation perspectives for clients and practitioners and, subsequently, I will discuss how the notion of co-created motivation is located within existing concepts of motivation.

9.1 Motivational Interviewing (MI)

Motivational Interviewing is a commonly used approach within the addiction treatment field (Hettema et al., 2005). Miller and Rollnick (2013: 12) define the motivational interviewing (MI) approach as 'a collaborative conversation style for strengthening a person's own motivation and commitment to change'. The key tenets of MI are identification, exploration and working with ambivalence (Miller and Rollnick, 2013). Collaboration, acceptance, evocation and compassion are the four key ingredients of the spirit of MI (Miller and Rollnick, 2013). Motivational Interviewing requires practitioners to offer a specific communication style based on a unique combination of being both directive and client-centred (Miller and Rollnick, 2013). The practitioners support their clients in developing motivation to change and overcoming ambivalence. The findings of the qualitative strands demonstrate that both practitioners and clients reflected on practitioners' impact on their clients, such as, in developing and supporting motivation to change and acquire healthy lifestyle for clients. Lundahl et al. (2010: 137) discuss four areas of practitioners' skills and knowledge; expressing empathy, developing discrepancy, working with ambivalence, and supporting a client's self-efficacy. In this study, clients highlighted that empathy is key to their relationship with their practitioners. They also reported that practitioners' challenging interventions (developing discrepancy) helped them to address their ambivalence in relation to stop drinking. Clients reported that they preferred to work with practitioners who supported them in developing their self-efficacy, that is, self-confidence that they can stop drinking and maintain their abstinence.

The idea of co-created motivation is built on the existing knowledge of client and practitioner-focused motivations such as Motivational Interviewing and staff-focused motivation impacted by compassion fatigue, and the findings of this study. The notion of co-created motivation does not negate the significance and relevance of the existing theories of motivation but add a different perspective to better understand that how these seemingly and as usually portrayed in the existing literature 'separate' concepts, are actually interlinked and inter-dependent.

Meta-analyses studies such as Burke et al. (2003), Hettema et al. (2005), Vasilaki et al. (2006), and Lundahl et al. (2010) support the evidence of effectiveness of MI and these studies are explored further below.

Burke et al. (2003) presented a meta-analysis comprised of 30 controlled clinical trials involving adapted motivational interviewing-based interventions in relation to problematic behaviours such as alcohol, drugs, poor diet, and lack of exercise. They reported that motivational interviewing-based interventions demonstrated similar rates of treatment outcome effectiveness compared with other active treatment models (Burke et al., 2003). A UK-based meta-analytic review on the efficacy of motivational interviewing by Vasilaki et al. (2006) included 22 randomised controlled trials of motivational interviewing-based treatment interventions. They concurred with Burke et al's (2003) overall findings that motivational interviewing is an effective model in relation to alcohol misuse.

Another meta-analysis based on 72 clinical trials by Hettema et al. (2005) demonstrated an average effect size (d=0.77) relating to short term (at one-month follow up stage) between-group comparisons. In these clinical trials, clients were randomly assigned to two groups – to receive or not to receive motivational interviewing interventions. Motivational interviewing demonstrated small to medium positive effects in improving health outcomes. However, this effect size decreased to 0.30 at one-year follow-up stage (Hettema at al., 2005). The effect sizes were larger (greater health outcomes) in relation to ethnic minority groups and when MI was delivered in a non-manualised manner (Hettema et al., 2005). They also reported that the effectiveness of MI greatly varied across different studies across different targeted client groups and client problems, practitioners, and organisational settings and, therefore, further research is required to understand how MI works (Hettema et al., 2005). Lundahl et al. (2010) included 119 studies in their meta-analysis of the last 25 years of empirical studies of motivational interviewing. They reported that motivational interviewing demonstrated statistically significant effectiveness on counselling outcomes. The above studies did not consider the relational dimensions of client-practitioner therapeutic relationship and the concept of co-created might be one explanation for the above reported successful therapeutic outcomes.

Lundahl and Burke (2009) presented a systematic review of four published meta-analyses on the effectiveness of motivational interviewing. These included the four meta-analyses mentioned above; Burke et al. (2003), Hettema, et al. (2005), Vasilaki, et al. (2006), and Lundahl et al. (2009). They reported that, compared with no treatment, MI is 10-20% more effective and it is equally effective (when comparing with other treatment models) in relation to substance use issues, such as alcohol, drugs and tobacco, risky behaviour and improving client commitment to counselling (Lundahl and Burke, 2009). Client-related demographic and clinical variables such as age, gender, and severity of problems were unrelated to treatment outcomes and individual motivational interviewing sessions were more effective than group-based interventions (Lundahl and Burke, 2009). The findings of this study with a very large dataset suggest that variable such as age and ethnicity did make a difference, however, this study was not focused on MI interventions.

The founders of MI, Miller and Rollnick (2013: 19) rely on the Rogerian philosophy of a client-centred approach and its basic tenet, that is, empathy. Elliot et al. (2019: 246) define empathy as ‘understanding the other person’s feelings, perspectives, experiences, or motivations’. Rogers (1959: 210-11) defines empathy as, ‘to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person, but without ever losing the "as if" condition’. According to Elliot at al. (2019) empathy is an interpersonal and unidirectional process that is provided by a practitioner to a client. On this basis, in my viewpoint the notion of empathy is primarily based on an individualistic client view. It is not surprising therefore, that it has been given a central position in counselling/psychotherapy approaches that are mainly based on Western cultural norms and are inherently individualistic. The findings of this study challenge the notion of individualistic or dualistic approaches and instead support the theory of the ‘person-world’ as inseparable entities.

For a true relational approach (dialogical approach) the focus is not just the client but the practitioner and the space in-between the two. It involves the practitioner making their own phenomenological experiences available to themselves and their clients, in the service of their clients.

Motivational interviewing (Millller and Rollnik, 2013) certainly moved on from 1970s' or 80s' addiction treatment approaches that were largely based on 'expert practitioners' and 'in need of help – clients' to a more empathic and relational approach. However, the roots of MI remained in an individualistic world viewpoint, where it claims that a practitioner's interventional style could influence a client's behaviour. It does not consider the practitioner's phenomenological experiences as vital data for the practitioner-client relationship. The working model of co-created motivation, located in this research, promotes the importance of both practitioners and clients' experiences and motivation. The findings of practitioners' interviews highlight that practitioners' motivation to work with their clients also impact their therapeutic relationship with clients. More specific discussion in relation to clients' motivation is presented below (6.3).

All clients in the focus group study in this research preferred to work with someone with a personal addiction history. In my view, this preference was not only based on the factual information of practitioners' personal addiction history and an assumption that they could understand the client better. It was also about the impact of sharing personal phenomenological experiences with clients and its positive impact on the practitioner-client relationship. Practitioners' openness to share their own experiences, regardless of whether addiction-related or not, offers enhanced relational experiences to clients. In addition, by sharing personal addiction experiences, practitioners move from an 'expert' position to 'a position of person' (Clarkson, 2003) and therefore facilitate a more relationally satisfying encounter for both parties.

On the basis of the above discussion, this research thesis proposes that a fifth ingredient could be added to the scope of motivational interviewing, that is, the **dialogical relationship** to the other four MI ingredients – collaboration, acceptance, evocation and compassion (Miller and Rollnick, 2013). This would have two potential impacts; it will move MI from a person-centred base (an inherently dualistic approach) to a gestalt therapy theory camp (a field theory-based approach) and it would further support other MI ethos' such as collaboration and acceptance. Such a change will be in line with MI's pioneers' (William Miller and Stephen Rollnick) recent attempt to move away from the position of pathologising clients by removing the notion of 'resistance' in their third edition of Motivational Interviewing (Miller and Rollnick, 2013). A field theory-based concept such as

co-created motivation is inherently incompatible with pathologising clients. In the next section, I will explore practitioners' motivation and compassion fatigue.

9.2 Practitioners' motivation - Compassion fatigue

The findings of this research show that practitioners' motivation to work with their clients fluctuates depending on a range of factors such as workload, output-based targets, funding cuts, lack of resources, and perceived lack of clients' commitment to engage with the service experienced as clients' non-attendance and relapses. No previous research is available which has focused on practitioners' motivation to work with alcohol dependent clients. Previous studies in the wider context such as social care, counselling, psychologists and mental health show that researchers and theoretical authors explore the concepts of compassion fatigue, burnout and vicarious traumatisation, and how they impact practitioners' emotional wellbeing and motivation to work (Jenkins and Baird, 2002). It could be concluded that previous research primarily explored practitioners' emotional wellbeing and motivation to work in a much broader sense instead of focusing on micro level changes in practitioners' motivation, that changes from client to client or situation to situation. The following discussion will explore the notion of practitioners' motivation to work with their clients in relation to compassion fatigue.

The findings of practitioners' interviews showed evidence that there were signs of compassion fatigue or burnout when practitioners were pleased when their clients did not attend their sessions. Practitioners reported that an extensive workload meant that they relied on clients' non-attendance to complete their administrative tasks. Compassion fatigue (CF) or burnout is defined as 'a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment' (Maslach, 2003: 2). Maslach (2003) states that burnout is directly linked to the helper's (or practitioner's) motivation. 'Once emotional exhaustion sets in, people feel they are no longer able to give of themselves to others. "It's not that I don't want to help, but that I can't – I seem to have a 'compassion fatigue'. I just can't motivate myself to climb one more mountain' (Maslach, 2003: 3). Practitioners 'deal' with their burnout by withdrawing from their clients and encompassing what could be described as a 'lip service' attitude. This is reported by participants of the focus group (clients' perspectives) in this study where they felt distant and not engaged with those practitioners

who appeared to be delivering a distant and withdrawn service. Participants of the focus group strand (clients' perspectives) also stated that at times they felt like 'numbers instead of real people'. Maslach (2003:3) explores this notion in relation to compassion fatigue and states that "they [practitioners] pigeonhole people into various categories and then respond to the category rather than to the individual."

The concept of vicarious traumatisation (VT) has developed in parallel to that of the notion of burnout. Pearlman and Saakvitne (1995: 31) describe VT as the 'cumulative transformative effect upon the trauma therapist of working with trauma survivors of traumatic life events'. Many alcohol dependent clients report histories of complex traumatic experiences such as child sexual abuse, physical and emotional abuse, assaults, bereavement and loss, and imprisonment. Alcohol practitioners routinely work with clients with complex emotional and mental health histories. Alcohol practitioners, who are not always appropriately trained and lack experience of working with complex emotional issues, are particularly at risk of burnout (Jenkins and Baird, 2002). This is likely to have a negative impact on the practitioners' willingness and capacity to engage fully with their clients. Therefore, this means the agency needs to ensure that the practitioners are appropriately trained and offered an effective and efficient on-going clinical supervision (Driscoll, 2007). Wheeler and Richards (2007: 4) state that clinical supervision is 'an essential aspect of ethical and effective therapy, and is seen as the cornerstone of continuing professional development'.

In the above section, I have discussed that practitioners impact their clients' motivation to change their drinking behaviour and that their capacity to work effectively is impacted by their working conditions. The findings of the qualitative strands in this research demonstrated that interpersonal and environmental factors also impact clients' attendance at their sessions. In recent years, researchers have become increasingly interested in exploring the factors that contribute to positive therapeutic outcomes. In the next section, I will discuss two major studies in the alcohol addiction field; project MATCH (Project MATCH research group, 1997) and UKATT (UKATT research team, 2005).

9.3 What works in therapy?

The findings of this study highlighted a range of factors that negatively impact clients' attendance at a community-based alcohol agency. These included, practitioner-client therapeutic relationship, practitioners and clients' motivation to work together, negative impact of funding cuts, and administrative and travelling issues for clients. In the following section, I will discuss that instead of specialist techniques of different treatment approaches, the therapeutic relationship contributes to the positive treatment outcomes.

Both project MATCH and UKATTT studies (details provided below) demonstrated that different treatment modalities led to positive treatment outcomes. In my view, a specific feature of practitioner-client encounters actually determine the treatment outcome instead of any specialist techniques of different treatment modalities. This specific feature is 'co-created motivation' that supports both the practitioner and client to mutually engage with each other and work towards mutually agreed outcome.

The findings of Project MATCH, one of the largest alcohol studies based in the USA, explored the effectiveness of different therapeutic models (12-session twelve-step facilitation therapy, 12-session cognitive behaviour therapy, and 4-session motivational enhancement therapy). Its findings showed that all three treatment approaches were effective (Project MATCH research group, 1997). Project MATCH involved randomly assigning 1726 clients from 30 treatment centres across the USA to the above-mentioned treatment approaches. A range of client-related outcome measures were recorded, for example; alcohol intake severity and dependency, mental and cognitive issues, social functioning, readiness of change, gender, religion, self-efficacy, anger, autonomy, and social functioning (Project MATCH research group, 1997). The study included an evaluation of client treatment outcomes at different stages; 3-month intervals for the 15-month period after the treatment ended and 39-month follow up at the selected sites. They concluded that clients in all three treatment approaches demonstrated significant improvements both in relation to their drinking and associated domains of life functioning (Project MATCH research group, 1997). Two assumptions can be made based on the findings of the Project MATCH; The first assumption is that different addiction treatment approaches are equally beneficial to clients and that is in line with Wampold et al.'s (1997) work in the

psychotherapy field reiterating the Dodo bird verdict[9]. The second assumption, treatment–client matching as a predicting factor for a positive treatment outcome, is not supported.

Cutler and Fishbain (2005) challenged the findings of Project MATCH and presented contradictory results based on their secondary analysis of Project MATCH data. They reported that the three treatment modalities used in Project MATCH were not particularly effective for people with alcohol addiction issues and the clients who did not receive any treatment had shown significant improvement in relation two outcome variables: percentage days abstinent (PDS) and drinks per drinking day (DDD) (Cutler and Fishbain, 2005). They analysed drinking patterns among three groups; 1. Clients who dropped out immediately (no treatment received), 2. Clients who dropped out after one session and 3. Clients who attended 12 sessions. They reported the following results; the first group of clients with no treatment showed significant improvement, the second group with one session performed worse than the first group (no treatment), and the third group with 12 sessions showed significant improvement in their first week (62% improved relating to PDA) and only 4% improvement in the remaining 11 sessions (Cutler and Fishbain, 2005). This study challenges the notion that clients' recovery is dependent on treatment attendance or engagement. They also cautioned against overstated effectiveness of treatment approaches because such an attitude could have unhelpful consequences for clients, practitioners and overall service provision. The above discussion demonstrates that there has been a widespread interest to discover what works in the therapeutic encounter and previous research is divided between two extreme positions – all therapies work or nothing works.

A UK-based research project UKATT (UK Alcohol Treatment Trial) also concluded similar findings, that two different therapeutic approaches Social Behaviour and Network Therapy (SBNT) and Motivation Enhancement Therapy (MET) were equally effective in supporting clients with alcohol issues (UKATT research team, 2005). The UKATT research design was based on a pragmatic randomised trial. Clients from seven alcohol service sites around three different English cities were interviewed at three stages; during treatment (n=742), at three-month post treatment discharge stage (n=689), and at twelve months

[9] Dodo bird effect – Rosenzweig (2002) introduced the concept of common factors in psychotherapy in his pioneering paper in 1936. He proposed that common factors in different psychotherapy modalities contribute to positive therapeutic outcomes.

(n=617). They considered alcohol intake units, alcohol dependence, and alcohol associated problems as the key outcome measures comparing the effectiveness of two treatment modalities, that is, SBNT and MET (UKATT research team, 2005). It is worth noticing that a 'no treatment group' was not included in this study due to ethical reasons as the UKATT did not want to deprive a client group from professional help (UKATT research team, 2005).

In brief, both UKATT and MATCH projects findings were consistent with Norcross and Lambert (2019) that treatment methods and techniques contribute relatively less in the overall therapeutic outcomes. Norcross and Lambert (2019) present two summary findings based on the last 50 years of published research in relation to factors associated with therapeutic outcomes. The first summary reports the following estimated percentages of therapeutic outcomes; expectancy (placebo effect) 15%; common factors (variables found in most therapy approaches) 30%; techniques (15%) and client's extra-therapeutic change (self-change, spontaneous remission, social support, fortuitous events) 40% (Norcross and Lambert, 2019, p.11). Their second summary focuses on the percentage of therapeutic outcome attributable to therapeutic factors; 'treatment method 10%, therapy relationship 15%, client contribution 30%, individual therapist 7%, other factors 3%, and unexplained variance 35%' (Norcross and Lambert, 2019:12). It is important to note that unexplained variance is the largest percentage (35%) and similarly extra-therapeutic factors amount to 40% of overall therapeutic outcomes. It is possible that co-created motivation, as yet unidentified in such studies, may go some way to explaining this variance. In my opinion, more qualitative based research is required to explore 'unexplained' factors linked with client's behaviour change. There is a consensus in the previous research that effective therapeutic relationship is an essential ingredient for successful therapy outcomes, however, there is a paucity of research explaining what constitutes effective therapeutic encounters. To explore is further, I will discuss the notion of the dialogical relationship – a person to person therapeutic interaction between a practitioner and client.

9.4 The dialogical relationship

The concept of co-created motivation is based on the notion that both practitioners and clients mutually impact each other in the therapy room. In this study, clients reported that they preferred to work with those practitioners who presented 'personal self' instead

of ‘professional facade’. In my opinion, practitioners work on a relational specturm between two polarities with their clients; a pracitioner as a ‘professional’ working with inter-personal dynamics or a practitoiner as a ‘person’ working within professional boundaries. The notion of co-created motivation demands a practioner as a ‘person’ position. This is also what clients suggested in this study. Yontef (2002) describes this ‘personal’ position as a dialogical relationship (the term used in Gestalt Therapy Theory literature to describe the real relationship) as between a pracitioner and client.

A 'real’ relationship or dialogical relationship (between client and practitioner) can be described as a person-to-person meeting based on a genuine encounter, where there is no pretence of being a distant professional. Buber (1970: 54) posits that people “exist within a relational dynamic that influences the very experience of the ‘I’ – our sense of self. There is no ‘I’ except in the ‘I’ of the ‘I-Thou’ and the ‘I-It’”.

Gelso (2014: 119) describes a real therapeutic relationship as ‘the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives/ experiences the other in ways that befits the other’. Realistic experience of the other and genuineness are the two key elements of the real relationship, that is, how ‘real’ the two people experience each other in the therapy room (Gelso et al., 2019). Jacobs (1989) describes the dialogical relationship as surrendering to the ‘in-between’ space between two people – practitioner and client. This surrendering requires being fully available to the other (client), to themselves (practitioner), and to the therapeutic relationship (Joyce and Sills, 2018). In line with Jacobs (1989) and Joyce and Sills’ (2018), co-created motivation requires practitioners to be able to offer the dialogical relationship to their clients. This ability relies on practitioners’ capacity to be self-aware, be available and responsive to their clients’ needs and have access to appropriate support.

Yontef (2002: 23) states that ‘every intervention, every moment of therapy, is not only a technical event but also a moment of interpersonal contact.’ The practitioner makes their own experiences in the therapy room available to clients in the service of clinical work. Practitioners’ phenomenological experiences offer valuable data for the relational encounter in addition to clients’ phenomenological experiences;

> ‘The human heart yearns for contact – above all it yearns for genuine dialogue… Each of us secretly and desperately yearns to be “met” to be recognized in our uniqueness, our fullness, and our vulnerability. We yearn to be genuinely valued by others as who we are, even that we are. The being of each of us needs to be revered – by ourselves, but also by others. Without that, we are not fulfilled – we are not fully ourselves’. (Hycner and Jacobs, 1995: 9).

On the basis of the above quote, it could be argued that for Hycner and Jacobs (1995) a person’s organismic self-regulation process (Perls et al. 1951) depends on the availability, accessibility, compatibility, and permeability of truly meeting with the other. For a person to exist as a functioning and creative being, dynamic ever-evolving relational contact is a prerequisite. The practitioner’s availability in a therapeutic encounter is crucial to client’s engagement and this is what Yontef (2002) describes as presence. Joyce and Sills (2018) describe presence as the practitioner’s commitment to be fully present to the client, ‘she [the practitioner] brings all of herself and is willing to meet the client honestly and authentically. In doing so, she allows herself to be touched and moved by the client, to be affected.’ (Joyce and Sills, 2018: 39). Hycner and Jacobs (1995) further describe the dialogic relationship as ‘an attitude of genuinely feeling/sensing/experiencing the other person as *a person* (not an object or part-object), and a willingness to deeply ‘hear’ the other person’s experience without pre-judgement. Furthermore, it is the willingness to ‘hear’ what is not being spoken, and to ‘see’ what is not visible’ (Hycner and Jacobs, 1995: xi). This means that alcohol practitioners need to offer the dialogical relationship to their clients in order to enhance the efficacy of practitioner-client meetings in the therapy room. This also requires alcohol support agencies to ensure that their workforce are provided sufficient training and on-going clinical supervision on relational aspects of clinical work.

Participants of the focus group (clients) responded to my enquiry about whether practitioners’ personal addiction experience had an impact on their treatment experiences, by saying that they felt more equal, heard and understood and ‘felt met by their practitioners’. The therapeutic advantages of practitioner-client relational horizontalisation have been presented as I-Thou relationship (I-You or Dialogical relationship) in Gestalt therapy theory (Yontef, 2002). I define relational horizontalisation as a two-fold process; i) practitioners to acknowledge inherent power dynamics in the therapy room and avoid

power blindness attitude, that is, practitioners and clients are equal in the therapy room, and ii) practitioners constantly work towards relational equality. As clients pointed out in this study, working with a practitioner with extended relational capacity in the therapy room significantly helped them to feel understood and supported. Clients also indicated that they were more likely to attend their sessions when working with relationship-focused practitioners compared to manual-focused practitioners.

9.5 Co-created motivation

The working model of co-created motivation is about recognising co-created experiences between a practitioner and client. As stated above, practitioners and clients impact upon each other both positively and negatively. Whatever happens in the therapy room, is experienced by both parties in their therapeutic encounter, and belongs to both practitioners and clients. Therefore, a client's attendance at their sessions cannot be solely attributed to the individual client. It is a relational problem, that is, the practitioner-client interaction.

Motivational Interviewing and PRIME Theory mainly focus on a client's motivation, whereas, the notions of compassion fatigue and burnout refer to practitioners' motivations. The concept of co-created motivation integrates the above-mentioned concept of dialogical relationship and field theory (Parlett, 2005). The idea of co-created motivation challenges the long-standing and well-established addiction theories and treatment models. Wollants (2013) states that the person and his/her world are inseparable, they are interdependent and together make the dynamic whole. People cannot be understood in isolation to their environmental or field conditions. The interaction between people and their environment is dynamic and therefore constantly changing, both parts – person and environment – constantly and proactively influence each other. Despite the rationality of this interdependent dynamic relational outlook, most psychology or psychotherapy theories and treatment models persistently view clients or patients as independent individuals – they are 'regarded as a neurobiological unit with a separate consciousness, possessing psychological traits or properties' (Parlett, 2005: 115).

In this study, clients specifically highlighted the importance of welcoming, confidential, respectful and private space in relation to their motivation to attend their

sessions. It is important for alcohol service providers to consider their building environment and its potential impact on their service users. In my view, involving clients in designing and developing interior infrastructure and decorations of the building would significantly enhance clients' satisfaction and attendance rates. The key challenges to this suggestion are lack of funding and resources available to improve the existing buildings and many service providers use rented venues with little room to improve the interior settings. Work environment also significantly impacts the job satisfaction of staff members (Leder et al., 2016). It requires a significant change to service design and delivery approaches, that is, to actively involve service users and frontline staff members in designing and developing of all aspects of service delivery including assessment protocols, opening times, types of interventions offered (individual, group, drop-in sessions), administrative protocols, and service satisfaction feedback processes.

Wollants (2012) further states that the focus of any therapeutic encounter has to be the person-field interplay. Clients proactively impact their field and are impacted by their field conditions. A client's field includes his/her practitioner. Similarly, practitioners proactively influence their field including their clients and impacted by their field conditions. Using Wollants' (2012: 3) 'interactional person-world' model offers innovative thinking that could be applied to alcohol practitioners and their work with clients. Alcohol practitioners and clients influence each other's motivation to engage in treatment and therefore attend their sessions. The following diagram (Figure 9.2) illustrates possible individual factors and their interplay with the other person.

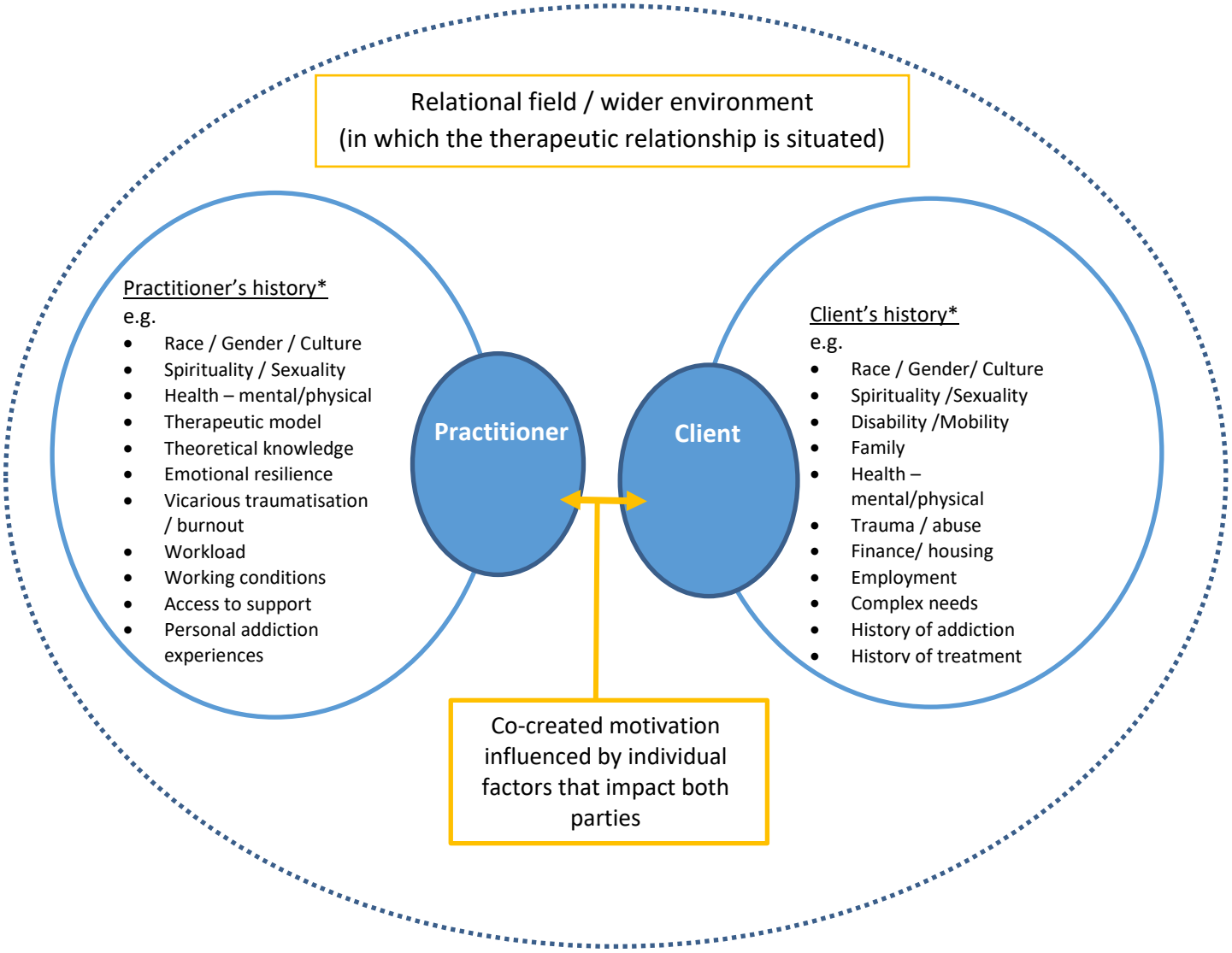


Figure 9.2: Illustration of practitioner-client relational interplay, adapted from Mahmood (2020)

*The different lists for clients and practitioners presented here are only to represent more relevant domains to their roles. The practitioners' and clients' lists could be identical with additional specific domains added such as; for practitioners, organisational context, compassion fatigue, theoretical background.

Figure 9.2 illustrates that both the practitioner and client bring the three-dimensional experiences into the therapy room, that is, their present (the here-and-now)

experiences in the room, their past histories and future concerns or anticipations. Both the past experiences and the future speculations impact the here-and-now interactions. This means that practitioners must show greater awareness of their own processes and commit to an empathic attitude towards their clients. It is worth noting that all participants in the individual interviews with practitioners in this study reported feeling relieved when their clients did not turn up for their appointments. Some practitioners also reported that they felt over-worked and stressed dealing with complicated clients' issues. Practitioners reported a range of issues contributing to their burnout, such as, poor working conditions, service delivery targets, pressure of long waiting list, stress of dealing with very complex client issues (such as, safeguarding, child protection, self-harm, domestic abuse, violence, suicide), lack of funding, and theoretical disagreement (how best to work with clients) with management.

Addiction is a recurring or relapsing condition (West and Brown, 2013) and therefore addiction treatment is often slow and includes several relapses. Staff motivation can also be affected by the slow pace of addiction treatment, particularly if the person is denying their problematic use. This can be hard work for a low paid third sector workforce. In addition, consistent funding cuts in the last decade severely impacted the third sector workforce. Similarly, clients' motivation to drink and to attend their sessions fluctuates depending on a range of factors, such as, mental health, social support, easy access to treatment, alcohol used as a self-medication, and treatment stage.

When two people (client and practitioner) meet with the intention to develop a working alliance to work towards an agreed therapeutic goal, it is the space in-between client and practitioner (the therapeutic encounter) that determines the success of their joint venture. Much of the therapeutic encounter is viewed as a unidirectional – the practitioner supporting the client. The key question here is what is going on for the practitioner in the treatment room? The concept of co-created motivation invites practitioners to be more self-aware and explore how they (as a person and professional) impact their clients and how they are impacted by their clients as a matter of routine in their clinical supervision sessions.

Personal therapy sessions, personal development activities and effective clinical supervision sessions should be available to practitioners. This, however, has additional

resource allocation implications and both clients and practitioners referred to lack of sufficient funding and its negative impacts on clients' engagement. On the other hand, investing in practitioners' personal and professional development will enhance practitioners' wellbeing, address job burnout, self-awareness, and therefore positively impact practitioner-client therapeutic experiences. Investing in the workforce development is likely to lead to reduction in clients' DNA rates and save additional resources currently used to deal with clients' non-attendance at their sessions.

It is important, and in the service of clients, that practitioners address their own motivation to work with their clients and find support to regularly recharge their appetite to support others. This study set out to explore ways to improve clients' attendance in practitioners and clients' views. Consistent, supportive, energising, challenging and client-practitioner-centred supervision is essential in order to develop and sustain effective clinical practice and improve clients' attendance rates. The qualitative strands in this research highlight the significance of the therapeutic relationship to attendance and is viewed as a crucial ingredient in the recovery journey of clients. A substantial research body suggests that an effective therapeutic relationship is crucial to successful outcome of the therapeutic work (Gelso and Carter, 1994; Castonguay, Constantino and Holtforth, 2006; Cooper, 2008; Duff and Bedi, 2010).

9.6 Chapter summary

I have presented a novel and pioneering working model of 'co-created motivation' – a relational model of motivation. The key tenet of this concept is that clients and practitioners' motivation impact each other, including their motivation to engage, attend their alcohol support sessions and work together. The notion of co-created motivation also includes wider field factors such as travelling distance to the agency, transport, location of the agency, building environment, confidentiality and privacy, administrative process and assessment processes. The client, the practitioner, the organisational policies, the service commissioning approach, and family or social support network are all parts of the wider field and impact clients' engagement and attendance. A person is inseparable from their environment and constantly impacts, and is impacted by, his/her environment. This non-dualistic (unitary) field theory concept requires a paradigm shift, that is, a rethinking about

clients' engagement and attendance at addiction support services from an individualistic and mainly intrapersonal issue to a system's issue. This is at the core of co-created motivation.

Chapter 10 Conclusions and Recommendations

This study is the first of its kind to explore reasons for clients' non-attendance at a community-based alcohol service and what can be done to improve their attendance from both practitioners' and clients' perspectives and using a mixed methods approach. The quantitative strand was based on the secondary analysis of the largest existing dataset ever used in this field of study. It comprised 194,679 appointments relating to the attendance of 22,405 clients over a four-year period (Jan 2010-Dec 2013). The qualitative strands were based on practitioners' interviews and clients' focus group. No previous study has been found that included both clients' and practitioners' views to explore clients' non-attendance. The literature review showed a range of research exploring clients' attendance at appointments. However, no research has been found that covered both quantitative and qualitative data collection and analysis specifically focusing on clients with alcohol addiction issues and their non-attendance at their appointments.

The overall aims of this study were; to explore reasons for clients' non-attendance, practitioners' and clients' views and experiences about clients' non-attendance, and what can be done to improve clients' attendance. According to practitioners, certain client characteristics (the most prominent being younger clients, BAME people, and people with complex needs or in early recovery stages) were linked with higher non-attendance rates. Forgetfulness was reported by both groups (clients and practitioners) as the most common reason for clients' non-attendance. DNA is also reported as a systems need – practitioners rely on the missed appointment times to undertake their administrative tasks. The key findings of the clients' focus group analysis show that positive client-practitioner relationships support higher attendance rates. It suggests that practitioners' lived experiences of addiction further enhance the client-practitioner relationship. Both groups of participants (clients and practitioners) referred to a lack of funding and resources impacting directly on service provision and clients' engagement. Both groups of participants (practitioners and clients) suggested a range of steps to improve such as prompt follow up, telephone support in-between sessions, creative engagement interventions, consistent

appointment reminder system (for example, text message reminders), and offering a flexible service.

Importantly, the findings led to the development of a novel concept of co-created motivation – a relational model of motivation. Practitioners and clients influence each other and proactively impact their co-created experiences in the counselling room and motivation to engage in a therapeutic encounter. The idea of co-created motivation is based on the findings of this research and is informed by the integration of Gestalt therapy theory (Wollants, 2012) and addiction theories such as Prime theory (West and Brown, 2013) and Motivational Interviewing (Miller and Rollnick, 2013). It is founded in the post-Cartesian philosophy that rejects the notion of dualism (person-world two separate entities). This study challenges the traditional dualistic viewpoint and presents a theory that both practitioners and clients impact each other's motivation to work together.

Overall, this research project makes an important and novel contribution to knowledge about clients' non-attendance at a community-based alcohol service. It has explored a complex picture of reasons for clients' non-attendance, practitioners and clients' experiences and possible ways to further improve clients' attendance.

The concept of co-created motivation demands a paradigm shift from an individualistic worldview to understanding 'person-world' as an inseparable entity. This requires a change in our attitude and approach to how we see our clients' issues with addiction and treatment engagement as solely their own problem, towards an attitude and approach which recognizes their issues as part of a client-environment dynamic interaction. Therefore, for any meaningful addiction support, it would be essential to develop a supportive environment that nourishes clients to acquire and rely on an environmental support. For the agency in which this research was based, this means reviewing their service delivery protocols. Using a field theory (Parlett, 2005) lens on addiction, challenges the notion of addiction primarily as an intrapersonal issue and proposes addiction as a person's response to his/her field condition, or it could be argued as the person's best possible response to his/her field stresses, applying the concept of creative adjustment (Joyce and Sills, 2018).

The following Table 10.1 summaries the key contributions of this research;

Table 10.1 Key contributions of this research

What is already known on this topic
• Certain clients are more likely to not attend or drop out from addiction services such as younger clients, BAME group, and clients with complex mental health issues. • SMS text message reminders can improve attendance. • Practitioner-client therapeutic alliance is crucial for clients' attendance at their appointments.
What this study adds
• A new working model of 'co-created motivation' proposing that both the practitioner and the client impact and are impacted by each other including their motivation to work together. • Flexible appointment system, short waiting times, use of phone and online interventions, sufficient funding and resources for the service, and reflective practitioner-client working alliance could improve clients' attendance rate. • Practitioners' experiences about clients' engagement and attendance were explored. Issues of extensive workload and burnout impact practitioners and they rely on clients' non-attendance to complete their administrative tasks.

In the following discussion the limitations and strength of the research, implications for policy, service provision and future research will be explored.

10.1 Limitations and strengths

The key limitation was being unable to recruit a larger group of clients for individual interviews, mainly those clients who had a history of missing sessions. This means their voices are missing from this research and could offer greater insight into the reasons for DNAs which may differ from those who participated in this research. Further qualitative

research undertaking semi-structured individual interviews with clients with the history of consistent DNAs would be particularly useful in this area. A further limitation relates to the qualitative data analysis, given all the qualitative data were analysed by the researcher. To further enhance the credibility of the qualitative data analysis more than one researcher independently analysing data would have been ideal. Schmidt (2004) recommends 'consensual coding' (p.256), that is; two or more research team members independently undertake their coding and then compare their coding. Consensual coding was neither feasible nor customary for PhD research work. However, being a doctoral researcher, coding and analyses were shared and extensively discussed with the research supervisors. In addition, I presented the results of the quantitative strand to an independent MPhil to PhD transfer panel and also presented at two national research conferences.

The quantitative strand, as based on secondary dataset, posed many data analysis challenges. The dataset application was developed over the period of five years going through several database application revisions and gradually included additional data entry fields as per local service level agreements. Data entry was inconsistent at times and there were data missing in many areas due to different data entry practices at different projects. Certain variables were not recorded such as religion and sexuality. Some variables had too many sub-categories and different projects interpreted those categories differently, such as employment status. The employment status table (Table 9 – Chapter 4) shows highest DNA rates in the 'not known' column. This could mean that practitioners did not ask this question to their clients or clients refused to answer this question. In sum, these data are missing.

In terms of strengths, this research was the first to examine clients' non-attendance at a community-based alcohol support service using a mixed methods approach including an extensive secondary dataset of 194,679 session records, making it the largest sample used in this area. This research also included practitioners' and clients' perspectives (qualitative strands) to explore their experiences of non-attendance and suggestions to improve clients' attendance. This research benefitted from data collected from one of the main addiction support services in the West Midlands.

As a result of this mixed methods approach, one of this project's strengths was the ability to triangulate the data and demonstrate that there were similarities and differences

relating to this mode of data collection. Data triangulation enhances the overall understanding of the phenomenon of research interest (Carter, 2014). Flick (2004, p.183) describes applications of triangulation as 'a validation strategy, as an approach to the generalization of discoveries, and as a route to additional knowledge'. Triangulation is 'the display of multiple, refracted realities simultaneously' (Denzin and Lincoln, 2013: 10). Flick (2004: 178) explains triangulation as 'the observation of the research issue from (at least) two different points'. Flick (2004:179) presents five categories of triangulation on the basis of Denzin (1978) work; 'triangulation of data, investigator triangulation, within-method triangulation, between-method triangulation, and triangulation of theories'. This research benefitted from the triangulation of data (qualitative strand – practitioners and clients' perspectives) and between-method triangulation (mixed methods research). Table 8.1 shows shared concepts between practitioners and clients and certain client factors such as age and ethnicity highlighted in both quantitative and qualitative strands.

10.2 Implications

The results and findings of this research study have implications for policy makers, commissioners, service delivery, and front-line practitioners. This section will be divided in three sections: policy implications, practice implications, and research implications.

10.2.1 Policy implications

The working model of co-created motivation has significant implications for the entire treatment system. A paradigm shift is required at alcohol addiction treatment policy level from seeing addiction and treatment engagement as an individual's issue to a system's issue. A person's excessive drinking is a response to their field conditions and therefore, their recovery should be supported by attention to their field conditions. Excessive drinking when used as self-medication to block out emotional pain and external stresses, consequently blocks out support from the wider environment/field. In light of this, it is important that alcohol agencies support their clients to accept and utilise support from their environment such as family and friends' support (Copello et al., 2006). It is also crucial that practitioners strive to offer a 'person-to-person' relationship (Clarkson, 2003: 152) to their clients. The dialogical relationship (Yontef, 2002) or person-to-person therapeutic

relationship is a meeting based on a genuine encounter between two human beings, where there is no pretence of being a distant professional.

The research findings have direct implications for service providers, commissioners, policy makers and practitioners. It is crucial that service commissioners (usually local government authorities) consider the implications of funding cuts on the service provision and clients. Recent trends of consistent gradual year-on-year funding cuts have been very detrimental to some of the most vulnerable people of our society. Additional specific challenges for alcohol service provision are related to integrated drug service policies where no specific funds are ring fenced for alcohol treatment provision. Drug service provisions consume the large share of the funding available due to many reasons; specialist staffing needs; maintenance prescriptions (such as methadone), associated health issues such as blood borne virus screening and referrals, associated criminal justice and health problems. In this austerity climate, there is a growing concern for the clients with alcohol-related issues due to the lack of sufficient resources. Here are the key policy change suggestions:

- Consider issues of negative impact of funding cuts and austerity on service provision and clients' engagements and their recovery journey. Consistent financial support is crucial for alcohol services to design and implement effective and efficient service delivery. Lack of appropriate service resources negatively impacts upon clients' attendance rates.
- The findings of this research suggest that the practitioner-client working alliance is important. The commissioning services and interventions needs to consider those approaches that are most likely to consider co-created motivational factors. Cognitive behavioural therapy, behavioural therapies or short-term therapies are considered as effective psychological interventions (NICE, 2011). None of these therapies, as mentioned in NICE guidelines, are inherently equipped to work on relational dimensions of client-practitioner working alliance. Therefore, revising NICE guidelines and including relational therapies such as Gestalt Therapy could improve clients' overall attendance rates.
- To ensure staff are appropriately supported in their work to avoid staff relying on certain percentage of clients' non-attendance to complete their daily tasks.

- Targeted service provision for clients with higher non-attendance rate such as younger clients, BAME group, and clients with additional complex needs.

10.2.2 Practice implications

The working model of co-created motivation has significant practice implications. It requires a paradigm shift from seeing addiction and treatment engagement as an individual's issue to a system's issue. Practitioners' relational awareness is crucial to clients' engagement and attendance. It requires alcohol agencies to not only shift support from 'manual-based' interventions to 'client-centred' treatment plans but also to 'relational and field-focused' work.

The key practice implications for service providers are as follows;

- To offer appropriate training to staff in delivering meaningful treatment plans and interventions embedded in 'co-created motivation', 'person-to-person therapeutic relationship', and 'field-focused work' phenomena.
- Clear service engagement model in relation to younger and BAME clients. This should include staff training and appropriate changes in service delivery practices such as age and culturally sensitive interventions.
- To ensure consistent use of text message reminders.
- Effective use of modern technology such as smart phones and video chat services.
- More focused and proactive engagement during early stages of treatment including in-between sessions phone calls.
- This research demonstrated that most clients preferred to work with practitioners in recovery and therefore consider increasing the number of in-recovery practitioners and peer support.
- Reducing waiting time between assessment and first session.
- Offer appropriate staff training in relation to the assessment process. Assessment process should be conducted in a sensitive and engaging manner.
- To introduce an ongoing client feedback system.

- To offer appropriate training to staff in relation to working with pertinent client issues such as shame, self-stigmatisation, denial, resistance to change, and issues of differences (such as ethnicity, gender, sexuality, religion).
- Staff motivation and wellbeing could be supported by appropriate clinical supervision and case management support.

10.2.3 Research implications

This research has achieved the stated aims of exploring reasons for clients' non-attendance and possible solutions to reduce clients' non-attendance. However, it paves the way for further research focusing on;

- Further research exploring co-created motivation and its impact of clients' attendance, motivation, and overall treatment goals.
- Individual interviews with clients with the history of consistent DNAs.
- Comparing clients' attendance pre and post universal text message reminders provision
- Exploring practitioners' motivation before and after the sessions compared with clients' motivation before and after the session.
- Comparing the impact of traditional outpatient-based appointment system with remote sessions (such as phone, video meeting platforms) on clients' engagement and drinking patterns. This seems more relevant than ever due to the current Covid-19 pandemic.
- Exploring any correlation between appointment attendance and clients' drinking patterns.
- Undertaking action research to explore the impact of a short training on relational therapeutic approach on clients' non-attendance rate.

I stated in the first paragraph of this thesis (Chapter 1) that my quest was to find out the missing link in understanding clients' non-attendance at a community-based alcohol agency. Six years of hard work and I believe the answer is – co-created motivation. I knew that the practitioner-client therapeutic relation was crucial to the client engagement and treatment outcomes. This study added a new insight into the dynamics of practitioner-client

relationships in addiction treatment. For a successful therapeutic encounter, it is important that practitioners demonstrate three-dimensional awareness of - self, the client, and the in-between space (Joyce and Sills, 2018) and truly commit to active partnership in the therapy room. Immediate field conditions such as building environment, waiting times, confidentiality and privacy, and assessment procedures, and wider field conditions such as family dynamics, history of trauma, abuse, and previous treatment experiences, should be considered in the therapeutic work in order to improve clients' attendance at treatment sessions. Both parties play a part and co-create relational dynamics that impact everything that happens between them. This research suggests that ignoring this relational dynamic will not maximise people's attendance nor help practitioners to ensure their humanity and personal qualities positively influence the support they offer.

References

Abraham, C. and Michie, S. (2008) 'A Taxonomy of Behavior Change Techniques Used in Interventions.' *Health Psychology,* 27(3) pp. 379-387.

Acevedo, A., Garnick, D., Ritter, G., Horgan, C. and Lundgren, L. (2015) 'Race/ethnicity and quality indicators for outpatient treatment for substance use disorders.' *The American Journal on Addictions,* 24, pp. 523-531. [Online] [Accessed on 26th May 2017] DOI: 10.111/ajad.12256

Adame, A. L. and Leitner, L. M. (2011) 'Dialogical constructivism: Martin Buber's enduring relevance to psychotherapy.' *Journal of Humanistic Psychology*, 51, pp. 41–60. [Online] [Accessed on 26th May 2017] DOI:10.1177/0022167810379959

Adamson, J. and Templeton, L. (2012) *Silent voices: supporting children and young people affected by parental alcohol misuse.* Office of the Children's Commissioner. [Online] [Accessed on 11th June 2016] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/07/FINAL_OCC_Report_Silent_Voices_Parental_Alcohol_Misuse_FULL_REPORT_Sept_2012_0.pdf

Agyapong, V. I. (2013) 'Six-months outcomes of a randomised trial of supportive text messaging for depression and comorbid alcohol use disorder.' *Journal of Affective Disorders*, 151 (1), pp. 100-104.

Akter, S., Doran, F., Avila, C. and Nancarrow, S. (2014) 'A qualitative study of staff perspectives of patient non-attendance in a regional primary healthcare setting.' *The Australasian Medical Journal*, 7(5), pp. 218-231. [Online] [Accessed on 12th July 2019] DOI: 10.21767/AMJ.2014.2056

Al Ghaferi, H., Bond, C. and Matheson, C. (2017) 'Does the biopsychosocial-spiritual model of addiction apply in an Islamic context? A qualitative study of Jordanian addicts in

treatment.' *Drug and Alcohol Dependence*, 172, pp. 14-20. DOI: 10.1016/j.drugalcdep.2016.11.019

Alang, S. M. (2019) 'Mental health care among blacks in America: Confronting racism and constructing solutions.' *Health Services Research*, 54(2), pp. 346-355. [Online] [Accessed on 3rd September 2019] DOI: 10.1111/1475-6773.13115

Al-Ansari, B., Thow, A., Day, C.A. and Conigrave, K.M. (2015) 'Extent of alcohol prohibition in civil policy in Muslim majority countries: the impact of globalization.' *Addiction*, 111, pp. 1703-1713. [Online] [Accessed on 3rd September 2019] DOI: 10.1111/add.13159

Alcohol Change UK (2018) *The alcohol change report.* [Online] [Accessed on 11th November 2019] https://s3.eu-west-2.amazonaws.com/files.alcoholchange.org.uk/images/AC-Lauch-report-online.pdf?mtime=20181114152753&focal=none

Alcohol Change UK (n.d.) *Alcohol statistics*. [Online] [Accessed on 9th Feb 2018] https://alcoholchange.org.uk/alcohol-facts/fact-sheets/alcohol-statistics

Alessandrini, G., Ciccarelli, R., Battagliese, G., Lombardo, G., De Rosa, F., Messina, M.R., Vitali, M., Pisciotta, F., Nanut, M., Attlia, M.L., and Ceccanti, M. (2018) 'Treatment of alcohol dependence. Alcohol and the young: social point of view.' *Riv Psichiatr,* 53(3), pp. 113-117. DOI: 10.1708/2925.29412

American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders: DSM-5*. Arlington, VA, American Psychiatric Association.

Andersen, K. (2019) 'White fragility: why it's so hard for white people to talk about racism.' *Journal of College & Character*, 20 (2), pp. 187-189 [Online] [Accessed on 12th July 2019] DOI: 10.1080/2194587X.2019.1591288

Andersen, R.M. (1968) *Behavioral model of families' use of health services: research series*. Chiacago, IL: Centre for Health Administration Studies.

Andersen, R. M. (1995) 'Revisiting the behavioral model and access to medical care: does it matter?' *Journal of Health and Social Behavior*, 36(1), pp. 1-10. [Online] [Accessed on 17th Nov 2017] DOI: 10.2307/2137284

Anderson, D.J., McGovern, J.P. and DuPont, R.L. (1999) 'The origins of the Minnesota model of addiction treatment - a first person account.' *Journal of Addiction Diseases*, 18(1), pp.107-114. DOI: 10.1300/j069v18n01_10

Anderson, P. and Baumberg, B. (2006) *Alcohol in Europe*. London: Institute of Alcohol Studies.

Anderson, P., Møller, L. and Galea, G. (2011) Alcohol in the European Union Consumption, harm and policy approaches. WHO. [Online] [Accessed 8th September 2016]. https://www.euro.who.int/__data/assets/pdf_file/0003/160680/e96457.pdf

Arfken, C. L., Klein, C., di Menza, S. and Schuster, C. R. (2001) 'Gender differences in problem severity at assessment and treatment retention.' *Journal of Substance Abuse Treatment,* 20(1)*,* pp. 53-57. DOI: 10.1016/S0740-5472(00)00155-0

Babbar, S., Adams, D.R., Becker-Haimes, E.M., Skriner, L.C., Kratz, H.E., Cliggitt, L., Inacker, P. and Beidas, R.S. (2018) 'Therapist turnover and client non-attendance.' *Children and Youth Services Review*, 93, pp. 12-16. [Online] [Accessed on 29th October 2019] DOI: 10.1016/j.childyouth.2018.06.026

BACP (2018). *Ethical framework for the counselling professions*. [Online] [Accessed 9th April 2019]. https://www.bacp.co.uk/events-and-resources/ethics-and-standards/ethical-framework-for-the-counselling-professions/

BACP (2019) Working online in the counselling professions: Good Practice in Action 047. [Online] [Accessed on 12th November 2020] https://www.bacp.co.uk/media/2162/bacp-working-online-supplementary-guidance-gpia047.pdf

Bager-Charleson, S. and Rijn, V. B. (2011) Understanding assessment in counselling and psychotherapy. Exeter: Learning Matters Ltd.

Ball, S.A., Carroll, K.M., Canning-Ball, M. and Rounsaville, B.J. (2006) 'Reasons for dropout from drug abuse treatment: Symptoms, personality, and motivation.' *Addictive Behaviors*, 31(2), pp. 320-330. [Online] [Accessed on 2nd March 2016] DOI: 10.1016/j.addbeh.2005.05.013

Balnaves, M. and Caputi, P. (2001) Introduction to quantitative research methods. London: Sage Publications Ltd.

Bandura, A. (1977) 'Self-efficacy: toward a unifying theory of behavioral change.' *Psychological Review, 84*(2), pp. 191–215. DOI: 10.1037/0033-295X.84.2.191

Bassuk, A.L., Hanson, J., Greene, R.N., Richard, M. and Laudet, A. (2016) 'Peer-delivered recovery support services for addictions in the United States: a systematic review.' *Journal of Substance Abuse Treatment*, 63, pp. 1-9. [Online] [Accessed on 12th July 2019] DOI: 10.1016/j.jsat.2016.01.003

Beisser, A.R. (1970) 'The paradoxical theory of change.' *In* Fagan, J. and Shepherd, I.L. (eds.) *What is Gestalt Therapy*. New York: Harper & Row Publishers.

Bhopal, K. and Preston, J. (eds.) (2012) *Intersectionality and "race" in education*. London: Routledge.

Bien, T. H. and Burge, R. (1990) 'Smoking and drinking: a review of the literature.' *International Journal of the Addiction*, 25(12), pp. 1429-1454. DOI: 10.3109/10826089009056229.

Black, T.R. (2005) *Doing quantitative research in the social sciences*. London: Sage Publications Ltd.

Blatt, S. J., Sanislow, C. A. III, Zuroff, D. C. and Pilkonis, P. A. (1996) 'Characteristics of effective therapists: Further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program.' *Journal of Consulting and Clinical Psychology, 64*(6), pp. 1276–1284. https://doi.org/10.1037/0022-006X.64.6.1276

Bloom, P. (2016) *Against empathy: The case for rational compassion*. New York: Ecco.

BMJ Best Practice (n.d.) *Wernicke Encephalopathy definition*. [Online] [Accessed on 8th February 2017] https://bestpractice.bmj.com/topics/en-gb/405

Boland, A., Cherry, G., and Dickson, R. (eds.) (2014) *Doing a systematic review: a student's guide*. London: Sage Publications Ltd.

Bonilla-Silva, E. (2015) 'The structure of racism in color-blind, "post-racial" America.' *American Behavioral Scientist*, 59(1), pp. 1358-1376. DOI: 10.1177/0002764215586826.

Booth, P.G. and Bennett, H.E. (2004) 'Factors associated with attendance for first appointments at an alcohol clinic and the effects of telephone prompting.' *Journal of substance Use*, 9(6), pp. 269-279. DOI: 10.1080/14659890410001711715

Boulton, M. (2009) 'Research ethics.' *In* Neale, J. (ed.) *Research methods for health and social care.* Basingstoke: Pelgrave Macmillian, pp. 31-46.

Bowlby, J. (1988) *A Secure Base*. Abingdon: Routledge.

Braun, V. and Clarke, V. (2013) *Successful qualitative Research: A practical guide for beginners*. London: Sage Publications Ltd.

Brooks, J. and King, N. (2012) 'Qualitative psychology in the real world: the utility of template analysis.' *In 2012 British Psychological Society Annual Conference*, 18th – 20th April; 2012, London, UK (Unpublished). [Online] [Accessed on 4th February 2017] http://eprints.huds.ac.uk.

Brorson, H. H., Ajo Arnevik, E., Rand-Hendriksen, K. and Duckert, F. (2013) 'Drop-out from addiction treatment: a systematic review of risk factors.' *Clinical Psychology Review*, 33(8), pp. 1010-1024. [Online] [Accessed on 3rd March 2016] DOI: https://doi.org/10.1016/j.cpr.2013.07.007

Brown, C.H., Bennett, M.E., Li, L. and Bellack, A.S. (2011) 'Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders.' *Addictive Behabviors*, 36(5), pp. 439-447. [Online] [Accessed on 3rd March 2016] DOI: 10.1016/j.addbeh.2010.12.001

Bryman, A. (2006) 'Integrating quantitative and qualitative research: How is it done?' Qualitative Research, 6(1), pp. 97–113.

Bryman, A. (2012) *Social research methods*. 4th ed. Oxford: Oxford University Press.

Buber, M. (1970) *I and thou* (W. A. Kaufmann, Trans.). Edinburgh, UK: T & T Clark.

Buchanan, J. (2010) 'Drug policy under New Labour, 1997–2010: prolonging the war on drugs.' *Probation Journal Special Edition*, 57(3), pp. 250–62.

Burke, B.L., Arkowitz, H. and Menchola, M. (2003) 'The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials.' *Journal of Consulting and Clinical Psychology,* 71(5), pp. 834-861. [Online] [Accessed on 18th April 2019] DOI: 10.1037/0022-006X.715.843

Burns, R.B. and Burns, R.A. (2008) *Business Research Method and Statistics Using SPSS*. London: Sage Publication Ltd.

Butt, J., Clayton, K., Gardner, Z., Huijber, K., Islam-Barret, F., Jeraj, S., Neale, R., Roberts, K., Whelan, A. and Wong, G. (2015) 'Better practice in mental health for black and minority ethnic communities'. UK, Race Equality Foundation and Mental Health Providers Forum.

Buykx, P., Irving, A., and Gavens, L. (2020) *Local alcohol treatment and recovery service commissioning practices and their perceived outcomes for service provision: An in-depth exploration.* Alcohol Change UK [Online] [Accessed on 12th November 2020] https://s3.eu-

west-2.amazonaws.com/files.alcoholchange.org.uk/documents/Local-alcohol-treatment-services-Executive-Summary.pdf?mtime=20200706174003&focal=none

Cabinet Office Strategy Unit (2004) *Prime Minister's Strategy Unit. Alcohol harm reduction strategy for England*. London: Cabinet Office. DOI: 10.1136/bmj.328.7445.905

Cann, W. (2012) 'Defining addiction, with more humanity?' *Contemporary Social Science*, 7(2), pp. 159-165. DOI: 10.1080/21582041.2012.683577

Carpenter, P.J., Morrow, G.R., Del Gaudio, A.C. and Ritzler, B.A. (1981) 'Who keeps the first outpatient appointment?' *American Journal of Psychiatry*, 138(1), pp. 102-105. DOI: 10.1176/ajp.138.1.102

Carroll, K.M., Libby, B., Sheehan, J. and Hyland, N. (2001) 'Motivational interviewing to enhance treatment initiation in substance abusers: an effectiveness study.' *The American Journal on Addiction*, 10(4), pp. 335-339. DOI: 10.1080/aja.10.4.335.339.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J. and Neville, A.J. (2014) 'The use of triangulation in qualitative research.' *Oncology Nursing Forum*, 41(5), pp. 545-547. DOI:10.1188/14.ONF.545-547

Cassidy, J. and Shaver, P.R. (2016) *Handbook of attachment: theory, research and clinical applications*. 3rd ed., New York: The Guildford Press.

Castonguay, L. G., Constantino, M. J. and Holtforth, M. G. (2006) 'The working alliance: where are we and where should we go?' *Psychotherapy: Theory, Research, Practice, Training, 43*(3), pp. 271–279. DOI: 10.1037/0033-3204.43.3.271

Centre for Substance Abuse Treatment (n.d.) *Treatment Improvement Protocol (TIP) Series*. SAMHSA, U.S. Department of Health and Human Services. [Online] [Accessed on 17th January 2016] https://www.centerforebp.case.edu/resources/tools/treatment-improvement-protocol-tip-series

CGL (Change, Grow, Live) (n.d.) [Online] [Accessed on 17th June 2018] https://www.changegrowlive.org/

Chou, I. and Narasimhan, K. (2005) 'Neurobiology of addiction.' *Nature Neuroscience*, 8(11), pp. 1427

Christians, C.G. (2013) 'Ethics and politics in qualitative research.' *In* Denzin, N.K. and Lincoln, Y.S. (eds.) *The landscape of qualitative research.* 4th ed., London: Sage Publications Ltd., pp. 125-168.

Christie, E. (2017) *Better care for people with co-occurring mental health and alcohol/drug use conditions: a guide for commissioners and service providers*. London: Public Health England Publications.

Cihan, A., Winstead, D.A., Laulis, J. and Feit, M.D. (2014) 'Attachment theory and substance abuse: etiological links.' *Journal of Human Behavior in the Social Environment,* 24(5), pp. 531-537. DOI: 10.1080/10911359.2014.908592.

Clarkson, P. (2003) *The Therapeutic Relationship.* 2nd ed., London: Whurr.

Claus, R.E. and Kindleberger, L.R. (2002) 'Engaging substance abusers after centralized assessment: predictors of treatment entry and dropout.' *Journal of Psychoactive Drugs*, 34(1), pp. 25-31. DOI: 10.1080/02791072.2002.10399933

Clemens, M. (2005) 'A gestalt approach to substance use, abuse and dependence.' *In* A. Woldt and S.Toman (eds.) *Gestalt Therapy: History, Theory and Practice*. London: Sage Publications Ltd. pp. 41-65

Cochrane, R. and Bal, S. (1990) 'The drinking habits of Sikh, Hindu, Muslim, and white men in the West Midlands: A community survey.' *British Journal of Addiction*, 85(6): pp. 759-769. [Online] [Accessed on 2nd May 2017] DOI: 10.1111/j.1360-0443.1990.tb01688.x

Cohen, A. D., Kaplan, D. M., Kraus, M., Rubinshtein, E. and Vardy, D.A. (2007) 'Nonattendance of adult otolaryngology patients for scheduled appointments.' *Journal of Laryngology and Otology*, 121(3), pp. 258-261.

Collins, P.H. and Bilge, S. (2016) *Intersectionality*. Cambridge, UK: Polity Press.

Cook, S., Heather, N. and McCambridge, J. (2015) 'The role of the working alliance in treatment for alcohol problems.' *Psychology of Addictive Behaviour*, 29 (1), pp. 371-281.

Coombes, L., Allen, D., Humphrey, D. and Neale, J. (2009) 'In-depth interviews.' *In* Neale,J. (ed.) *Research Methods for Health and Social Care*. Basingstoke: Palgrave MacMillan, pp. 197-210.

Cooper, H. (1988) *Synthesizing research: a guide for literature reviews*. London: Sage Publications Ltd.

Cooper, M. (2008) *Essential research findings in counselling and psychotherapy: the facts are friendly*. London: Sage Publications Ltd.

Copello, A. G., Velleman, R. D. B. and Templeton, L. J. (2005) 'Family interventions in the treatment of alcohol and drug problems.' *Drug and Alcohol Review*, 24(4), pp. 369-385. [Online] [Accessed on 18th May 2019] DOI: 10.1080/09595230500302356

Copello, A., Orford, J., Hodgson, R., Tober, G. and Barrett, C. (2002) 'Social behaviour and network therapy: Basic principles and early experiences.' *Addictive Behaviors,* 27(3), pp. 345-366. [Online] [Accessed on 18th May 2019] DOI: 10.1016/s0306-4603(01)00176-9

Copello, A., Williamson, E., Orford, J. and Day, E. (2006) 'Implementing and evaluating Social Behaviour and Network Therapy in drug treatment practice in the UK: a feasibility study.' *Addictive Behaviors*, 31(5), pp. 802-810. [Online] [Accessed on 18th May 2019] DOI: https://doi.org/10.1016/j.addbeh.2005.06.005

Costa, B. (2011) 'The creative cycle: receiving and giving help in a black and minority ethnic counselling service.' *Mental Health and Social Inclusion*, 15(4), pp.198-203. DOI: 10.1108/20428301111186840

Coughlan, M., Cronin, P. and Ryan, F. (2013) *Doing a literature review in nursing, health and social care*. London: Sage Publications Ltd.

Coulson, C., Ng, F., Geertsema, M., Dodd, S. and Berk, M. (2009) 'Client-reported reasons for non-engagement in drug and alcohol treatment.' *Drug and Alcohol Review*, 28(4), pp. 372-378. [Online] [Accessed on 27th June 2016] DOI: 10.1111/j.1465-3362.2009.00054.x

Coyne, I.T. (1997) 'Sampling in qualitative research. Purposeful and theoretical sampling; mearging or clear boundaries?' *Journal of Advanced Nursing*, 26(3), pp. 623-630.

Creswell, J. W. (2003) *Research design: qualitative, quantitative, and mixed methods approaches.* 2nd ed., London: Sage Publications Ltd.

Creswell, J.W. (2013) *Qualitative inquiry & research design: choosing among five approaches*. 3rd ed., London: Sage Publications Ltd.

Creswell, J.W. and Plano Clark, V.L. (2011) *Designing and conducting mixed methods research*. 2nd ed., London: Sage Publications Ltd.

Creswell, J.W. and Plano Clark, V.L. (2018) *Designing and conducting mixed methods research*. 3rd ed., London: Sage Publications Ltd.

Crocker, S.F. (2009) 'Phenomenology in Husserl and in Gestalt therapy.' *The British Gestalt Journal*, 18(1), pp. 18-28.

Crotty, M. (1998) *The foundations of social research: meaning and perspective in the research process*. London: Sage Publications Ltd.

Cunningham, J.A., Sobell, L.C., Sobell, M.B., Agrawal, S. and Toneatto. (1993) 'Barriers to treatment: Why alcohol and drug abusers delay or never seek treatment.' *Addictive Behaviors*, 18(3), pp. 347-353. DOI: 10.1016/0306-4603(93)90036-9

Curtis, S. L. and Eby, L. T. (2010) 'Recovery at work: The relationship between social identity and commitment among substance abuse counselors.' *Journal of Substance Abuse Treatment*, 39(3), pp. 248-254. [Online] [Accessed on 11th April 2017] DOI: https://doi.org/10.1016/j.jsat.2010.06.006

Cutler, R.B. and Fishbain, D.A. (2005) 'Are alcoholism treatments effective? The project MATCH data.' *BMC Public Health*, 5(75). DOI: 10.1186/1471-2458-5-75.

Daniels, M.K. and Jung, S. (2009) 'Missed initial appointments at an outpatient forensic psychiatric clinic.' *The Journal of Forensic Psychiatry & Psychology*, 20(6), pp. 964-973. [Online] [Accessed on 11th April 2017] DOI: 10.1080/14789940903174204

Davies, J.B. (1992) *The Myth of addiction*. Reading: Harwood Academic Publishers.

Dawood, R. and Done, J. (2020) 'An interpretative phenomenological analysis of service users' experiences in a psychosocial addictions intervention.' *Psychology and Psychotherapy: Theory, Research and Practice*. [Online] [Accessed on 11th April 2017] DOI: doi/full/10.1111/papt.12296

Deane, F. P., Wootton, D. J., Hsu, C. and Kelly, P. J. (2011) 'Predicting Dropout in the first 3 months of 12-step residential drug and alcohol treatment in an Australian sample.' *Journal of studies on Alcohol and Drugs,* 73(2), pp. 216-225. DOI: 10.15288/jsad.2012.73.216

Dearing, R.L., Barrick, C., Dermen, K.H. and Walitzer, K.S. (2005) 'Indicators of client engagement: Influences on alcohol treatment satisfaction and outcomes.' *Psychology of Addictive Behaviors*, 19(1), pp. 71-78. DOI: 10.1037/0893-164X.19.1.71

Deegan, P. E. and Drake, R. E. (2006) 'Shared Decision making and medication management in the recovery process.' *Psychiatric Services, 57* (11), pp. 1636-1639. DOI: 10.1176/ps.2006.57.11.1636

Denzin, N.K. (1978) *The research act: a theoretical introduction to sociological methods*. New York: McGraw-Hill.

Department of Health (2007) *Improving access to psychological therapies: specification for the commissioner-led Pathfinder programme.* [Online] [Accessed on 3rd May 2017] http://www.mhchoice.csip.org.uk/psychological-therapies/-iapt-commissionerled-pathfinder-sites/resources.html/

Department of Health (2009) *Signs for improvement – commissioning interventions to reduce alcohol-related harm.* [Online] [Accessed on 3rd May 2017] http://www.ias.org.uk/uploads /pdf/HSR/dh_104854.pdf

Denzin, N.K. and Lincoln, Y.S. (eds.) (2013) *The landscape of qualitative research.* 4th ed., London: Sage Publications Ltd.

Dewberry, C. (2004) *Statistical methods on organizational research: theory and practice.* London: Routledge.

DiAngelo, R. (2018) *White fragility: why it's so hard for white people to talk about racism.* London: Penguin Random House.

Dobkin, P. L., Civita, M. D., Paraherakis, A. and Gill, K. (2002) 'The role of functional support in treatment retention and outcomes among outpatient adult substance abusers.' *Addiction,* 97(3), pp. 347-356. DOI: 10.1046/j.1360-0443.2002.00083.x

Doukas, J. and Cullen, J. (2010) 'Recovered addicts working in the addiction field: pitfalls to substance abuse relapse.' *Drugs: Education, Prevention and Policy*. 17(3), pp. 216-231. DOI: 10.3109/09687630802378864

Drinkaware (n.d.) Health effects of alcohol. [Online] [Accessed on 10th Oct 2020] https://www.drinkaware.co.uk/facts/health-effects-of-alcohol/

Driscoll, J. (2007) *Practising clinical supervision: a reflective approach for healthcare professionals.* 2nd ed., UK: Elsevier Ltd.

Drug Strategy (2017) Drug strategy 2010: Reducing demand, restricting supply, building recovery: Supporting people to live a drug free life. [Online] [Accessed on 10th May 2018] https://www.gov.uk/government/publications/drug-strategy

Drummond, D.C., Cooper, T. and Glautier, S.P. (1990) 'Conditioned learning in alcohol dependence: implications for cue exposure treatment.' *British Journal of Addiction, 85*(6), pp. 725–743. DOI: 10.1111/j.1360-0443.1990.tb01685.x

Duff, C. and Bedi, R. (2010) 'Counsellor behaviours that predict therapeutic alliance formation: From the client's perspective.' *Counselling Psychology Quarterly*, 23(1), pp. 91-110. DOI: 10.1080/09515071003688165.

Economic and Social Research Council (ESRC). (2015) *ESRC framework for research ethics*. [Online] [Accessed on 20th June 2016] https://esrc.ukri.org/files/funding/guidance-for-applicants/esrc-framework-for-research-ethics-2015/

Elliot, R. Bohart, A.C., Watson, J.C. and Murphy, D. (2019) 'Empathy.' *In* Norcross, J.C. and Lambert, M.J. (eds.) *Psychotherapy Relationships that Works*. 3rd ed., Oxford: Oxford University Press, pp. 245-287.

Elliot, R., Bohart, A.C., Watson, J.A. and Greenberg, L.S. (2011) 'Empathy.' *Psychotherapy*, 48(1), pp. 43-49.

Erickson, C.K. and White, W.L. (2009) 'The neurobiology of addiction recovery.' *Alcoholism Treatment Quarterly*, 27(3), pp. 338-345. DOI: 10.1080/07347320903014255

Ewer, P. L., Teesson, M., Sannibale, C., Roche, A. and Mills, K. L. (2015) 'The prevalence and correlates of secondary traumatic stress among alcohol and other drug workers in Australia.' *Drug and Alcohol Review*, 34(3), pp. 252-258. DOI: 10.1111/dar.12204

Fahy, A. (2007) 'The unbearable fatigue of compassion: notes from a substance abuse counsellor who dreams of working at Starbucks.' *Clinical Social Work Journal*, *35*(3), 199 - 205. DOI: 10.1007/s10615-007-0094-4

Farley, J.E. and Flota, M. W. (2018) *Sociology*. 7th ed., Oxford: Routledge.

Farrimond, H. (2013) *Doing ethical research*. Basingstoke: Palgrave Macmillan.

Field, A.P. (2017) *Discovering Statistics Using SPSS.* 5th ed., London: Sage Publications Ltd.

Field, M., Mogg, K. and Bradley, B.P. (2004) 'Cognitive bias and drug craving in recreational cannabis users.' *Drug and Alcohol Dependence*, 74(1), pp. 105-111. DOI: 10.1016/j.drugalcdep.2003.12.005

Finaly, L. (2012) 'Five lenses for the reflexive interviewer.' *In* Gubrium, J.F. Holstein, J.A., Marvasti, A.B., and McKinney, K.D. (eds) *The Sage Handbook of Interview Research: The complexity of the craft.* 2nd ed., London: Sage Publications Ltd., pp. 317-332.

Finch, H., Lewis, J. and Turley, C. (2014) 'Focus groups.' *In* Ritchie, J., Lewis, J., McNaughton, N., and Ormston, R. (eds.) *Qualitative research practice*. 2nd ed., London: Sage Publications Ltd., pp. 211-242.

Finlay, L. (2016) *Relational integrative psychotherapy: engaging process and theory in practice*. West Sussex: John Wiley & Sons.

Flick, U. (2004) 'Triangulation in quality research.' *In* Flick, U., von Kardoff, E., and Steinke, I. (eds.) *A companion to qualitative research*. London: Sage Publications Ltd., pp.178-183.

Flick, U. (2009) *An Introduction of Qualitative Research*. 4th ed., London: Sage Publications Ltd.

Flick, U. (2015) *Introducing research methodology*. 2nd ed., London: Sage Publications Ltd.

Fontana, A. and Frey, J.H. (1994) 'Interviewing: the art of science'. In Denzin, N.K. and Lincoln, Y.S. (eds.), *Handbook of qualitative research*, London: Sage Publications Ltd., pp. 361-376

Foster-Turner, J. (2009) 'Focus groups'. *In* Neale, J. (ed.) *Research methods for health and social care.* Basingstoke: Pelgrave Macmillian, pp. 211 -223.

Fluckiger, C., Del Re, A.C., Wlodasch, D., Horvath, A.O., Solomonov, N. and Wampold, B.E. (2020) 'Assessing the alliance-outcome association adjusted for patient characteristics and treatment processes: a meta-analytical summary of direction comparison.' *Journal of Counseling Psychology*, Advanced online publication. [Accessed on 3rd July 2020] http://dx.doi.org/10.1037/cou0000424

Friend, K.B. and Pagano, M.E. (2005) 'Smoking cessation and alcohol consumption in individual in treatment for alcohol use disorders.' *Journal of Addictive Diseases*, 24(2), pp.61-75. DOI: 10.1300/J069v24n02_06.

Gabbatiss, J. (2019) 'UK facing 'addiction crisis' as councils cut funding for treatment while alcohol-related deaths soar.' *The Independent*. 11th February [Accessed on 15th May 2020]. https://www.independent.co.uk/news/health/alcohol-deaths-council-funding-cuts-drug-addiction-services-austerity-jonathan-ashworth-a8772301.html

Galvani, S. (2012) *Supporting people with alcohol and drug problems: making a difference*. Bristol: The Policy Press.

Garfield, S.L. (1994) 'Research on client variables in psychotherapy.' *In* Bergin, A.E. and Garfield, S.L. (eds.) *Handbook of Psychotherapy and behavior change*. 4th ed., New York: John Wiley & Sons, pp. 190-228.

Gatley, S.J., Volkow, N.D., Wang, G.J., Fowler, J.S., Logan, J., Ding, Y.S., and Gerasimov, M. (2005) 'PET imaging in clinical drug abuse research.' *Current Pharmaceutical Design*, 11(25), pp. 3203-3219.

Gelkopf, M., Levitt, S. and Bleich, A. (2002) 'An integration of three approaches to addiction and methadone maintenance treatment: the self-medication hypothesis, the disease model and social criticism.' *The Israel Journal of Psychiatry and Related Sciences*, 39(2), pp. 140-151.

Gelso C. (2014) 'Tripartite model of the therapeutic relationship: theory, research, and practice.' *Psychotherapy Research*, 24(2), pp. 117–131. DOI: 10.1080/10503307.2013.845920

Gelso, C. and Carter, J.A. (1994) 'Components of the psychotherapy relationship: their interacton and unfolding during treatment.' *Journal of Counseling Psychology*, 41(3), pp. 296-306.

Gelso, C., Kivlighan, D. and Markin, R. (2018) 'The real relationship and its role in psychotherapy outcome: a meta-analysis.' *Psychotherapy*, 55(4), pp. 434-444. DOI: 10.1037/pst0000183.

Gerard, N. (2017) 'Rethinking compassion fatigue.' *Journal of Health Organization and Management*, 31(3), pp. 363-368. DOI: 10.1108/JHOM-02-2017-0037

Gilder, D. A., Geisler, J. R., Luna, J. A., Calac, D., Monti, P. M., Spillane, N. S. and Ehlers, C. L. (2017) 'A pilot randomized trial of Motivational Interviewing compared to Psycho-Education for reducing and preventing underage drinking in American Indian adolescents.' *Journal of Substance Abuse Treatment*, 82, pp. 74-81. DOI: https://doi.org/10.1016/j.jsat.2017.09.004

Golder, S., Gillmore, M. R., Speaker, S. and Morrison, D. (2005) 'Substance use, related problems behaviours and adult attachment in a sample of high risk older adolescent women.' *Journal of Child and Family Studies*, 14(2), pp. 181-193. DOI: 10.1007/s10826-005-5046-6

GOV, UK (1998) *Data Protection Act 1998*. [Online] [Accessed on 3rd July 2016] https://www.gov.uk/data-protection/the-data-protection-act

GOV, UK (2016) *UK Chief Medical Officers' low risk drinking guidelines.* [Online] [Accessed on 3rd July 2017] https://assets.publishing.service.gov.uk/government/uploads/system /uploads/attachment_data/file/545937/UK_CMOs__report.pdf

GOV, UK (2020) Prime Minister's statement on coronavirus (COVID-19): 23 March 2020. [Online] [Accessed on 10th December 2020] https://www.gov.uk/government/speeches/pm-address-to-the-nation-on-coronavirus-23-march-2020

Gray, D., Wilson, M., Allsop, S., Saggers, S., Wilkes, E. and Ober, C. (2014) 'Barriers and enablers to the provision of alcohol treatment among Aboriginal Australians: a thematic review of five research projects.' *Drug and Alcohol Review*, 33(5), pp. 482-490. DOI: 10.1111/dar.12137.

Green, C.A., Polen, M.R., Dickinson, D.M., Lynch, F.L. and Bennett, M.D. (2002) 'Gender differences in predictors of initiation, retention, and completion in an HMO-based substance abuse treatment program.' Journal of Substance Abuse Treatment, 23(4), pp. 285-295. DOI: 10.1016/s0740-5472(02)00278-7

Greene, J. C., Caracelli, V. J. and Graham, W. F. (1989) 'Toward a conceptual framework for mixed-method evaluation designs.' *Educational Evaluation and Policy Analysis*, 11(3), pp. 255–274. DOI: 10.3102/01623737011003255

Greenwood, N., Habibi, R., Smith, R., and Manthorpe, J. (2015) 'Barriers to access and minority ethnic carers' satisfaction with social care services in the community: a systematic review of qualitative and quantitative literature.' *Health and Social Care in the Community*, 23(1), pp. 64-78. DOI: 10.111/hsc.12116

Greenwood, N., Holley, J., Ellmers, T., Bowling, A., and Cloud, G. (2017) 'Assessing satisfaction with social care services among black and minority ethnic and white British

carers of stoke survivors in England.' Health and Social Care in the Community, 25(5), pp. 1571-1580. DOI: 10.111/hsc.12298

Guba, E. G. and Lincoln, Y. S. (2005) 'Paradigmatic controversies, contradictions, and emerging confluences*.' In* Denzin, N. K. and Lincoln Y. S. (eds.) *The Sage handbook of qualitative research*. London: Sage Publications Ltd., pp. 191–215.

Guba, E.G. (ed.) (1990) *The paradigm dialog*. London: Sage Publications Ltd.

Guba, E.G. and Lincoln, Y.S. (1994) 'Competing paradigms in qualitative research.' *In* Denzin, N.K and Lincoln, Y.S. (eds.) *Handbook of qualitative research*. London: Sage Publications Ltd., pp. 105-117.

Gudjonsson, G., Hannesdottir, K., Agustsson, T., Sigurdsson, J.F., Gudmundsdottir, A., pordardottir, p., Tyrfingsson, p. and Petursson, H. (2004) 'Personality predictors of the failure of alcoholics to come for follow-up assessment.' *Personality and Individual Differences*, 37(4), pp. 805-813. DOI: 10.1016/j.paid.2003.11.006.

Gullo, M. J., Irvine, K., Feeney, G. F. X. and Connor, J. P. (2018) 'Short message service (SMS) reminders improve treatment attendance in alcohol dependence, but are less effective for patients high in impulsivity.' *Addictive Behaviors*, 87, pp. 97-100. [Online] [Accessed on 23rd Oct 2019] DOI: https://doi.org/10.1016/j.addbeh.2018.06.025

Gur, F., Gur, G. C. and Okanli, A. (2017) 'The effect of the cognitive-behavioral model-based psychoeducation and exercise intervention on quality of life in alcohol use disorder.' *Archives of Psychiatric Nursing*, 31(6), pp. 541-548. DOI: 10.1016/j.apnu.2017.07.005

Gurol-Urganci, I., de Jongh, T., Vodopivec-Jamsek, V., Atun, R. and Car, J. (2013) 'Mobile phone messaging reminders for attendance at healthcare appointments (review).' Cochrane *Database of Systematic Reviews*, 12, [Online] [Accessed on 11th May 2018] DOI: 10.1002/14651858.CD007458.pub3.

Guy, R., Hocking, J., Wand, H., Stott, S., Ali, H. and Kaldor, J. (2012) 'How effective are short message service reminders at increasing clinic attendance? A meta-analysis and systematic review.' *Health Services Research*, 47(2), pp. 614-632. DOI: 10.111/j.1475-6773.2011.01342.x.

Hakim, N., Thompson, A., and Coleman-Oluwabusola, G. (2019) An evaluation of the transition from BAME community mental health worker to IAPT low intensity psychological wellbeing practitioner. The Cognitive Behaviour Therapist, 12(15). DOI: 10.1017/S1754470X18000296.

Hall, W., Carter, A. and Barnett, A. (2017) 'Disease or developmental disorder: Competing perspectives on the neuroscience of addiction.' *Neuroethics*, 10, pp. 103–110. [Online] [Accessed on 9th November 2019] DOI: 10.1007/s12152-017-9326-7

Hall, W., Carter, A. and Forlini, C. (2015). 'The brain disease model of addiction: Is it supported by the evidence and has it delivered on its promises?' *The Lancet Psychiatry*, 2(1), 105–110. DOI: 10.1016/S2215-0366(14)00126-6

Hamilton, W., Luthre, M., Smith, T. and Evans, P. (2002) 'Non-attendance in general practice: a questionnaire survey.' *Primary Health Care Research and Development*, 3(4), pp. 226-230. DOI: 10.1191/1463423602pc106oa

Hampton-Robb, S., Qualls, R. C. and Compton, W. C. (2003) 'Predicting first-session attendance: The influence of referral source and client income.' *Psychotherapy Research*, 13(2), pp. 223-233. DOI: 10.1080/713869641

Harries, C. (2011) 'Charities: cuts and crisis: central government and local authority cuts mean that voluntary and community sector organisations are facing a funding crisis, with services for young, disabled and older people among the hardest hit.' *Community Practitioner*, 84(10), pp. 16-25.

Hasvold, P. E. and Wootton, R. (2011) 'Use of telephone and SMS reminders to improve attendance at hospital appointments: a systematic review.' *Journal of Telemedicine and Telecare*, 17(7), pp. 358-364. DOI: 10.1258/jtt.2011.110707

Heather, N. (1998) 'A conceptual framework for explaining drug addiction.' *Journal of Psychopharmacology*, 12(1), pp. 3-7. DOI: 10.1177/026988119801200101

Heather, N. and Robertson, I. (1997). *Problem drinking* (3rd ed.). Oxford: Oxford University Press.

Heaton, J. (2004) *Reworking qualitative data*. London: Sage Publications Ltd.

Hettema, J., Steele, J. and Miller, W. R. (2005) 'Motivational interviewing.' *Annual review of Clinical Psychology*, 1(1), pp. 91-111. DOI: 10.1146/annurev.clinpsy.1.102803.143833

Hewitt, D. and Cramer, D. (2010) *Introduction to Research Methods in Psychology*. 3rd ed., London: Pearson Education.

Horvath, A. O. and Bedi, R. P. (2002) 'The alliance.' *In* Norcross, J. C. (ed.) *Psychotherapy relationships that work: therapist contributions and responsiveness to patients*. Oxford: Oxford University Press, pp. 37 - 69.

Horvath, A.O. (2018) 'Research on the alliance: Knowledge in search of a theory.' *Psychotherapy Research*, 28(4), pp. 499-516. http://dx.doi.ord/10.1037/a0022186

Howe, K. R. (1988). 'Against the quantitative-qualitative incompatibility thesis or dogmas die hard.' *Educational Researcher*, 17(8), pp. 10–16. DOI: 10.3102/0013189X017008010

Hser, Y.I., Anglin, M.D. and Fletcher, B. (1998) 'Effects of program modality and client drug dependence history on drug use reduction.' *Journal of Substance Abuse Treatment*, 15 (6), pp. 513-523. DOI: 10.1016/s0740-5472(97)00308-5

Huggard, P., Law, J. and Newcombe, D. (2017) 'A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians.' *Australasian Journal of Disaster and Trauma Studies*, 21(2), pp. 65-72.

Hunt, J. and Eisenberg, D. (2010) 'Mental health problems and help-seeking behavior among college students.' *Journal of Adolescent Health*, 46 (1), pp. 3-10. DOI: 10.1016/j.jadohealth.2009.08.008.

Hurcombe, R., Bayley, M. and Goodman, A. (2010). Ethnicity and alcohol; A review of the UK literature. *Joseph Rowntree Foundation.* [Online] [Accessed on 4th October 2016] <http://www.jrf.org.uk/sites/files/jrf/ethnicity-alcohol-literature-review-full_0.pdf>

Hycner, R. and Jacobs, L. (1985) *The healing relationship in gestalt therapy: a dialogic/self psychology approach*. Gouldboro, USA: The Gestalt Journal Press.

Information Commissioner's Office (2012) *Anonymisation: managing data protection risk code of practice*. [Online] [Accessed on 3rd February 2016] https://ico.org.uk/media/1061/anonymisation-code.pdf.

Jackson, C. and Rizq, R. (2019) *The Industrialisation of Care: counselling, psychotherapy and the impact of IAPT*. Monmouth: PCCS.

Jackson, K. R., Booth, P. G., McGuire, J. and Salmon, P. (2006) 'Predictors of starting and remaining in treatment at a specialist alcohol clinic.' *Journal of Substance Use*, 11(2), pp. 89-100. DOI: 10.1080/14659890500143614

Jackson, K. R., Booth, P. G., Salmon, P. and McGuire, J. (2009) 'The effects of telephone prompting on attendance for starting treatment and retention in treatment at a specialist alcohol clinic.' *British Journal of Clinical Psychology*, 48(4), pp. 437-442. DOI: 10.1348/014466509X457469

Jacobs, L. (1989) 'Dialogue in gestalt theory and therapy.' *The Gestalt Journal*, 12(1), pp. 25-67.

Jacobs, L. (2017) 'Hopes, fears, and enduring relational themes.' *British Gestalt Journal*, 26(1), pp. 7-16.

Jayakumar, U.M. and Adamian, A.S. (2017) 'The fifth frame of colorblind ideology: maintaining the comforts of colorblindness in the context of white fragility.' *Sociological Perspectives*, 60(5), pp. 912-936. DOI: 10.1177/0731121417721910

Jellinek, E.M. (2010) *Disease concept of alcoholism*. USA: Martino Fine Books

Jenkins, S.R. and Baird, S. (2002) 'Secondary traumatic stress and vicarious trauma: a validation study.' *Journal of Traumatic Stress*, 15(5), pp. 423-432. DOI: 10.1023/A:1020193526843

Johansen, A. B., Kristiansen, E., Bjelland, I. and Tavakoli, S. (2019) 'Secondary traumatic stress in Norwegian SUD-therapists: Symptoms and related factors.' *Nordic Studies on Alcohol and Drugs*, 36(6), pp. 522-531. DOI: 10.1177/1455072519847014

Johnson, R. B. and Onwuegbuzie, A. J. (2004) 'Mixed methods research: A research paradigm whose time has come.' *Educational Researcher*, 33(7), pp. 14–26. DOI: 10.3102/0013189X033007014

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). 'Toward a definition of mixed methods research.' *Journal of Mixed Methods Research*, 1(2), pp. 112–133. DOI: 10.1177/1558689806298224

Joyce, P. and Sills, C. (2018) *Skills in gestalt counselling & psychotherapy*. 4th ed., London: Sage Publications Ltd.

Kandola, B. (2012) 'Focus groups.' *In* Symon, G. and Cassell, C. (eds.) *Qualitative Organization Research: Core Methods and Current Challenges*. London: Sage Publications Ltd., pp. 258-274.

Khantzian, E.J. (2012) 'Reflections on Treating Addictive Disorders: A Psychodynamic Perspective'. *The American Journal on Addiction*, 21(3), pp. 274-279. DOI: https://doi.org/10.1111/j.1521-0391.2012.00234.x

Khantzian, E.J. (2018) 'The self-medication Hypothesis and attachment theory: pathways for understanding and ameliorating addictive suffering'. In Gill, R. (2018) *Addictions From an Attachment perspective*. Oxon: Routledge, pp. 33-57

Kheirkhah, P., Feng, Q., Travis, L.M., Tavakoli-Tabasi, S. and Sharafkhaneh, A. (2016) 'Prevalence, predictors and economic consequences of no-shows.' BMC Health Services Research, 16 (13). [Online] [Accessed on 12th July 2019] DOI: 10.1186/s12913-015-1243-z

King, A.C. and Canada, S.A. (2004) 'Client-related predictors of early treatment drop-out in a substance abuse clinic exclusively employing individual therapy.' *Journal of Substance Abuse Treatment,* 26 (3), pp. 189-195. DOI: 10.1016/S0740-5472(03)00210-1

King, N. (2012) 'Doing template analysis.' *In* Symon, G. and Cassell,C. (eds.) *Qualitative Organization Research: Core Methods and Current Challenges*, London: Sage Publications Ltd., pp. 258-274

Kingsfund.org.uk (2020) 'The NHS budget and how it has changed.' [Online][Accessed on 14th November 2020] https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget

Kirk, R. (2017) 'Abab research design.' *In* Wenzel, A. (ed.) *The sage encyclopedia of abnormal and clinical psychology*, London: Sage Publications Ltd. DOI: 10.4135/97814833655817

Kitcheman, J., Adams, C. E., Pervaiz, A., Kader, I., Mohandas, D. and Brookes, G. (2008) 'Does an encouraging letter encourage attendance at psychiatric out-patient clinics? The Leeds

PROMPTS randomized study.' *Psychological Medicine*, 38(5), pp. 717-723. DOI: 10.1017/S0033291707001766

Korte, J.E., Rosa, C.L., Wakim, P.G. and Perl, H.I. (2011) 'Addiction treatment trial: how gender, race/ethnicity, and age relate to ongoing participation and retention in clinical trials.' *Substance Abuse and Rehabilitation*, 2, pp. 205-218. [Online] [Accessed on 2nd July 2016] DOI: 10.2147/SAR.S23796.

Kruse, G.R., Rohland, B.M. and Wu, X.Y. (2002) 'Factors associated with missed first appointments at a psychiatric clinic.' Psychiatric Services, 53(9), pp. 1173-1176. DOI: 10.1176/appi.ps.53.9.1173.

Kulesza, M., Matsuda, M., Ramirez, J. J., Werntz, A. J., Teachman, B. A. and Lindgren, K. P. (2016) 'Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender.' *Drug and Alcohol Dependence*, 169, pp. 85-91. [Online] [Accessed on 28th March 2019] DOI: https://doi.org/10.1016/j.drugalcdep.2016.10.020.

Kuusisto, K., and Lintonen, T. (2020) 'Factors predicting satisfaction in outpatient substance abuse treatment: a prospective follow-up study.' *Substance Abuse Treatment, Prevention and Policy,* 15 (35). [Online] [Accessed on 21st Sep 2020] DOI: https://doi.org/10.1186/s13011-020-00275-5.

Lacy, N.L., Paulman, A., Reuter, M.D. and Lovejoy, B. (2002) 'Why we don't come: patient perceptions on no-shows.' The Annals of Family Medicine, 2(6), pp. 541-545. DOI: 10.1370/afm.123

Langkamp, D. L., Lehman, A., and Lemeshow, S. (2010) 'Techniques for handling missing data in secondary analyses of large surveys.' *Academic Pediatrics*, *10*(3), 205–210. https://doi.org/10.1016/j.acap.2010.01.005

Larsen, D.L., Nguyen, T.D., Green, R.S. and Attkisson, C.C. (1983) 'Enhancing the utilization of outpatient mental health services.' *Community Mental Health Journal*, 19(4), pp. 305-320. DOI: 10.1007/BF00755411

Lavrakas, P.J. (2008) *Encyclopedia of survey research methods.* Thousand Oaks, CA: Sage Publications Ltd.

Lawson, G. (1982) Relation of counsellor traits to evaluations of the counselling relationship by alcoholics. *Journal of Studies on Alcohol*, 43(7), pp. 834-839. DOI: 10.15288/jsa.1982.43.834

Leder, S., Newsham, G.R., Veitch, J.A., Mancini, S., and Charles, K.E. (2016) 'Effects of office environment on employess satisfaction: a new analysis. *Building Research and Information*, 44(1), pp. 34-50, DOI: 10.1080/09613218.2014.1003176

Lefforge, N. L., Donohue, B., and Strada, M. J. (2007) Improving Session Attendance in Mental Health and Substance Abuse Settings: A review of Controlled Studies. *Behavior Therapy,* 38 (1), pp. 1-22. DOI: 10.1016/j.beth.2006.02.009

Leshner, A. (1997). Addiction is a brain disease, and it matters. *Science, 278 (5335), pp.* 45-47. DOI: 10.1126/science.278.5335.45

Levine, H. G. (1978) 'The discovery of addiction: changing conceptions of habitual drunkenness in America.' *Journal of Studies on Alcohol, 39*(1), pp. 143 -174. DOI: 10.15288/jsa.1978.39.143

Lewin, K. (1946, reprinted 2008) *Resolving social conflicts and field theory in social science***.** Washington, D.C.: American Psychological Association.

Lewis, A.E. (2004) ' "What Group?" Studying Whites and Whiteness in the era of "color-blindness" '. *Sociological Theory*, 22 (4), pp. 623-646. DOI: 10.1111/j.0735-2751.2004.00237.x

Lo, C.C. and Cheng, T.C. (2011) 'Racial/ethnic differences in access to substance abuse treatment.' *Journal of Health Care for the Poor and Underserved*, 22(2), pp. 621-637. DOI: https://doi.org/10.1353/hpu.2011.0054

Loughborough University (n.d.) Ethics Approvals (Human Participants) Sub-Committee: guidance notes for investigators. [Online] [Accessed on 4th May 2014] https://www.lboro.ac.uk/media/wwwlboroacuk/content/universitycommittees/ethicsapprovalshumanparticipantssub-committee/Data%20Collection%20and%20Storage.pdf

Lowenthal, D., Mohamed, A., Mukhopadhyay, S., Ganesh, K., and Thomas, R. (2012) 'Reducing the barriers to accessing psychological therapies for Bengali, Urdu, Tamil and Somali communities in the UK: some implications for training, policy and practice.' *British Journal of Guidance & Counselling,* 40(1), pp. 43-66. DOI: 10.1080/03069885.2011.621519

López-Goni, J.J., Fernandez-Montalvo, J. and Arteaga, A. (2011) 'Addiction treatment dropout: Exploring patients' characteristics.' *The American Journal on Addiction*, 21(1), pp. 78-85. [Online] [Accessed on 12th July 2019] DOI: 10.1111/j.1521-0391.2011.00188.x

Lowman, R.L., De Lange, W.H., Thomm, K.R. and Brady, C.P. (1984) 'Users and "teaser": Failure to follow through with initial mental health service inquires in a child and family treatment centre.' *Journal of Community Psychology*, 12, pp. 253-262

Lubman, D.L., Yucel, M. and Pantelis, C. (2004) 'Addiction, a condition of compulsive behavior? Neuroimaging and neuropsychological evidence of inhibitory dysregulation.' *Addiction*, 99(12), pp. 1491-1502. DOI: 10.1111/j.1360-0443.2004.00808.x

Luborsky, M. R. and Rubinstein, R. L. (1995) 'Sampling in qualitative research: Rationale, issues, and methods.' *Research on Aging*, 17(1), pp. 89-113. DOI: 10.1177/0164027595171005

Lundahl, B. and Burke, B. L. (2009) 'The effectiveness and applicability of motivational interviewing: a practice-friendly review of four meta-analyses.' *Journal of Clinical Psychology*, 65(11), pp. 1232-1245. DOI: 10.1002/jclp.20638

Lundahl, B.W., Kunz, C., Brownell, C., Tollefson, D. and Burke, B.L. (2010) 'A meta-analysis of motivational interviewing: twenty-five years of empirical studies.' *Research on Social Work Practice,* 20(2), pp. 137-160. DOI: 10.1177/1049731509347850

MacDougall, C. and Fudge, E. (2001) 'Planning and recruiting the sample for focus groups and in-depth interviews.' *Qualitative Health Research*, 11(1), pp. 117-126. DOI: 10.1177/104973201129118975

Mahmood, F. (2020) 'Can I please have White skin too?' *In*. Ade-Serrano and Nkansa-Dwamena, O. (eds.) *Applied psychology and applied professions working with ethnic minorities,* Leicester: The British Psychological Society, pp. 74-84

Mann, D. (2010) *Gestalt therapy 100 key points and techniques*. East Sussex: Routledge.

Marsden, J., Stewart, D., Gossop, M.m Rolfe, A., Bacchus, L., Griffiths, P., Clarke, K., and Strang, J. (2000) 'Assessing client satisfaction with treatment for substance use problems and the development of the Treatment Perceptions Questionnaire (TPQ)'. Addiction Research, 8 (5), pp. 455-470. DOI: 10.3109/16066350009005590.

Martin, C., Perfect, T. and Mantle, G. (2005) 'Non-attendance in primary care: the views of patients and practices on its causes, impact and solutions.' *Family Practice*, 22(6), pp.638-643. DOI: 10.1093/fampra/cmi076

Maslach, C. (2003) *Job burnout: the cost of caring*. Los Altos, CA: Malor Books.

Matthews, S., Dwyer, R. and Snoek, A. (2017) 'Stigma and Self-Stigma in Addiction.' *Journal of Bioethical Inquiry*, 14(2), pp. 275-286. DOI: 10.1007/s11673-017-9784-y.

Mayring, P. (2007) 'Introduction: Arguments for mixed methodology.' *In*. Mayring, P., Huber, G. L., Gurtler, L. and Kiegelmann, M. (eds.) *Mixed Methodology in Psychological Research*, Rotterdam/ Taipei: Sense Publishers, pp. 1–4

McCallum, S.L., Mikocka-Walus, A., Gaughwin, M.D., Andres, J.M. and Turnbull, D.A. (2015) 'I'm a sick person, not a bad person: patient experiences of treatments for alcohol use disorders.' *Health Expectations*, 19(4), pp. 828-841. DOI: 10.1111/hex.12379

Mccaul, M., Svikis, D. and Moore, R. (2001) 'Predictors of outpatient treatment retention: Patient versus substance use characteristics.' *Drug and alcohol dependence*. 62(1), pp. 9-17. DOI: 10.1016/S0376-8716(00)00155-1

McKay, M.T., Mcbride, N.T., Sumnall, H.R. and Cole, J.C. (2012) 'Reducing the harm from adolescent alcohol consumption: results from an adapted version of SHAHRP in Northern Ireland.' *Journal of Substance Use*, 17(2), pp. 98-121. DOI: 10.3109/14659891.2011.615884

McKellar, J., Kelly, J., Harris, Al. and Moos, R. (2006) 'Pretreatment and during treatment risk factors for dropout among patients with substance use disorders.' Addictive Behaviors, 31(3), pp. 450-460. DOI: 10.1016/j.addbeh.2005.05.024

McLean, S., Booth, A., Gee, M., Bhanbhro, S., Salway, S., Cobb, M. and Nancarrow, S. (2016) 'Appointment reminder systems are effective but not optimal: Results of a systematic review and evidence synthesis employing realist principles.' *Manual Therapy*, 25, e125. [Online] [Accessed on 12th July 2019] DOI: https://doi.org/10.1016/j.math.2016.05.230

McMahon, R.C., Kouzekanani, K. and Malow, R.M. (1999) 'A comparative study of cocaine-treatment completers and dropouts.' *Journal of Substance Abuse Treatment*, 16(1), pp. 17-22. DOI: 10.1016/S0740-5472(97)00317-6

McKnight, P. E, and McKnight, K.M. (2011) 'Missing data in secondary analysis.' *In* Trzesniewski, K., Donnellan, M., and Lucas, R. (eds) *Secondary Data Analysis : An Introduction for Psychologists* (1st ed.). American Psychological Association, pp. 83-101

Mearns, D. and Cooper, M. (2018) *Working at relational depth in counselling and psychotherapy*. London: Sage Publications Ltd.

Mearns, D., Thorne, B. and McLeod, J. (2013) *Person-centred counselling in action*. 4th ed., London: Sage Publications Ltd.

Meier, P.S., Barrowclough, C. and Donmall, M.C. (2005) 'The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature.' *Addiction*, 100(3), pp. 304-316. DOI: http://dx.doi.org/10.1111/j.1360-0443.2004.00935.x

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T. and de Visser, R. (2016) 'Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England.' *BMJ Open*, 6(11), e012337. [Online] [Accessed on 11th March 2018] DOI: 10.1136/bmjopen-2016-012337

Mennis, J. and Stahler, G.J. (2016) 'Racial and ethnic disparities in outpatient substance use disorder treatment completion for different substances. Journal of Substance Abuse Treatment, 63, pp. 25-33. DOI: https://doi.org/10.1016/j.jsat.2015.12.007

Meriam-Webster Dictionary (n.d.) *Addiction*.[Online] [Accessed on 6th January 2016] https://www.merriam-webster.com/dictionary/addiction

Merleau-Ponty, M. (1962) *Phenomenology of perception*. London: Routledge.

Mertens, D. and Hesse-Biber, S. (2013) 'Mixed methods and credibility of evidence in evaluation.' *New Directions for Evaluation*, 138, pp. 5-13. DOI: https://doi.org/10.1002/ev.20053

Mertens, D. M. (2003) 'Mixed methods and the politics of human research: The transformative-emancipatory perspective.' *In*. Tashakkori, A. and Teddlie, C. (eds.) *Handbook of mixed methods in social & behavioral research,* London: Sage Publications Ltd., pp. 135–164

Mitchell, A.J. and Selmes, T. (2007) 'Why don't patients attend their appointments? Maintaining engagement with psychiatric services.' *Advances in Psychiatric Treatment*; 13 (6), pp. 423-434. DOI: 10.1192/apt.bp.106.003202

Miller, W. R. (1998) 'Researching the spiritual dimensions of alcohol and other drug problems.' Addiction, 93(7), pp. 979-990. DOI: 10.1046/j.1360-0443.1998.9379793.x

Miller, W. R. and Rollnick, S. (2013) *Motivational interviewing: helping people change*. 3rd ed., New York: Guilford Press.

Milward, J., Lynskey, M. and Strang, J. (2014) 'Solving the problem of non-attendance in substance abuse services.' *Drug & Alcohol Review*, 33(6), pp. 625-636. DOI: 10.1111/dar.12194

Moeller, F.G, Barratt, E.S., Dougherty, D.M., Schmitz, J.M. and Swann, A.C. (2001) 'Psychiatric aspects of impulsivity.' *American Journal of Psychiatry*, 158(11), pp. 1783-1793. DOI: 10.1176/appi.ajp.158.11.1783

Moher, D., Liberati, A., Tetzlaff, J. and Altman, D.G., The PRISMA Group (2009) 'Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement.' *Public Library of Science Medicine,* 6(7), [Online] [Accessed on 6th March 2016] DOI:10.1371/journal.pmed1000097

Morgan, D.L. (1997) *Focus groups as qualitative research*. London: Sage Publications Ltd.

Morrey, T., Larkin, Mi., and Rolfe, A. (2020) What claims are made about clients and therapists' experiences of psychotherapy environments in empirical research? A systematic mixed-studies review and narrative synthesis. *Counselling and Psychotherapy Research*, 20, pp. 666-679. https://doi-org.mmu.idm.oclc.org/10.1002/capr.12336

Morse, J. (1998) 'Designing Funded Qualitative Research.' *In* Denzin, N. and Lincoln, Y. (eds.) *Strategies of Qualitative Inquiry*. London: Sage Publications Ltd., pp. 56-85

Morse, J. (2010) 'Procedures and practice of mixed method design: Maintaining control, rigor, and complexity.' *In* Tashakkori, A. and Teddlie, C. (eds.) *Sage handbook of mixed methods in social & behaviours Research*, London: Sage Publications Ltd., pp. 339-352

Morse, J. M. (1991) Approaches to qualitative-quantitative methodological triangulation. Nursing Research, 40(2), pp. 120–123

Muench, F. (2013) 'Developing a theory driven text messaging intervention for addiction care with user driven content.' *Psychology of Addictive Behaviors*, 27(1), pp. 315-321. DOI: 10.1037/a0029963.

Mullins, S.M., Suarez, M., Ondersma, S.J. and Page, M.C. (2004) 'The impact of motivational interviewing on substance abuse treatment retention: a randomized control trial of women involved with child welfare.' *Journal of Substance Abuse Treatment*, 27 (1), pp. 51-58. DOI: 10.1016/j.jsat.2004.03.010

Murphy, B., Cockburn, J. and Murphy, M. (1992) 'Focus groups in health research.' *Health Promotion Journal of Australia*, 2(2), pp. 37-40.

National Institute on Alcohol Abuse and Alcoholism (n.d.) *Review article reinforces support for brain disease model of addiction.* [Online] [Accessed on 4th Sep 2016] https://www.niaaa.nih.gov/research/niaaa-research-highlights/review-article-reinforces-support-brain-disease-model-addiction

NDTMS (n.d.) National Drug Treatment Monitoring System. [Online] [Accessed on 4th Sep 2016] https://www.ndtms.net/

Neal, R. D., Hussain-Gambles, M., Allgar, V. L., Lawlor, D. A. and Dempsey, O. (2005) 'Reasons for and consequences of missed appointments in general practice in the UK: questionnaire survey and prospective review of medical records.' *BMC Family Practice*, 6(1), pp. 47-47. DOI: 10.1186/1471-2296-6-47

Ng Fat, L., Shelton, N. and Cable, N. (2018) 'Investigating the growing trend of non-drinking among young people; analysis of repeated cross-sectional surveys in England 2005–2015.' *BMC Public Health* 18**,** 1090 (2018). https://doi.org/10.1186/s12889-018-5995-3

NHS (2011) *Treating Alcohol Misuse.* [Online] [Accessed on 4th November 2016] http://www.nhs.uk/Conditions/Alcohol-misuse/Pages/Treatment.aspx> [April 2012].

NHS (2015) *The risks of drinking too much*. [Online] [Accessed on 4th Sep 2016] http://www.nhs.uk/Livewell/alcohol/Pages/Effectsofalcohol.aspx

NHS (2019) *Statistics on smoking, England - 2019*. [Online] [Accessed on 17th June 2020]. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2019/part-3-smoking-patterns-in-adults-copy

NICE (2011) Alcohol – use Disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence. *The British Psychological Society and The Royal College of Psychiatrists*. [Online] [Accessed on 4thg Sep 2016] http://www.nice.org.uk/nicemedia/live/13337/53190/53190.pdf

Nicholson, P. (2003) 'Reflexivity, "bias" and the in-depth interview: developing shared meanings.' *In* Finaly, L. and Gough, B. (eds.) *Reflexviity: A practical guide for researchers in health and social sciences.* Oxford: Blackwell, pp. 133–45

Norcross, J.C. and Lambert, M.J. (eds.) (2019) *Psychotherapy relationships that works*. 3rd ed., Oxford: Oxford University Press,

Nordheim, K., Walderhaug, E., Alstadius, S., Kern-Godal, A., Arnevik, E. and Duckert, F. (2018) 'Young adults' reasons for dropout from residential substance use disorder treatment.' *Qualitative Social Work*. 17(1), pp. 24-40. DOI: 10.1177/1473325016654559

Nutt, D. (2013) *Addiction*. Oxford: Oxford University Press.

Nutt, D. and Nester, L. (2013) *Addiction: Oxford psychiatry library*. Oxford: Oxford University Press.

Ofcom (2019). *The communications market 2019*. [Online] [Accessed on 8th June 2020] https://www.ofcom.org.uk/research-and-data/multi-sector-research/cmr/cmr-2019

Oldham, M., Kellet, S., Miles, E. and Sheeran, P. (2012) 'Interventions to increase attendance at psychotherapy: a meta-analysis of randomized control trials.' *Journal of Consulting and Clinical Psychology*, 80(5), pp. 928-939. DOI: 10.1037/a0029630

Office for National Statistics (2019) *Alcohol-specific deaths in the UK: registered in 2018*. [Online] [Accessed on 8th June 2020] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/2018

Office for National Statistics (2019) *Young people not in education, employment or training (NEET), UK*: *February 2019*. [Online] [Accessed on 8th June 2020] https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/bulletins/youngpeoplenotineducationemploymentortrainingneet/february2019

Orford, J. (2001) 'Addiction as excessive appetite.' *Addiction*, 96(1), pp. 15-31. DOI: 10.1046/j.1360-0443.2001.961152.x

Orford, J., Hodgson, R., Copello, A., Wilton, S. and Slegg, G. (2009) 'To what factors client attribute change? Content analysis of follow-up interviews with clients of the UK Alcohol Treatment Trial.' *Journal of Substance Abuse Treatment,* 36, pp. 49-58. DOI: 10.1016/j.jsat.2008.04.005

Owuor J.O. A. and Nake, J. N. (2015) 'Internalised stigma as a barrier to access to health and social care services by minority ethnic groups in the UK'. UK, Race Equality Foundation.

Oxford English Dictionary (n.d.) *Addiction*. [Online] [Accessed on 3rd February 2016] http:www.oed.com

Paige, L. and Mansell, W. (2013) 'To attend or not attend? A critical review of the factors impacting on initial appointment attendance from an approach-avoidance perspective.' *Journal of Mental Health*, 22(1), pp. 72-82. DOI: 10.3109/09638237.2012.705924

Pal, B., Taberner, D. A.,Readman,L.P. and Jones,P. (1998) 'Why do outpatients fail to keep their clinic appointments? Results from a survey and recommended remedial actions.' International Journal of Clinical Practice, 52(6), pp. 436–437.

Paley, G. and Lawton, D. (2001) 'Evidence-based practice: accounting for the importance of the therapeutic relationship in UK National Health Service therapy provision.' *Counselling and Psychotherapy Research*, 1(1), pp. 12-17. DOI: 10.1080/14733140112331385198

Pallant, J. (2005). *SPSS Survival Guide: a step by step guide to data analysis using SPSS for Windows*. 3rd ed., Berkshire: Open University Press.

Pallant, J. (2013). *SPSS Survival Guide: a step by step guide to data analysis using SPSS for Windows*. 5th ed., Berkshire: Open University Press.

Palmer, R. S., Murphy, M. K., Piselli, A. and Ball, S. A. (2009) 'Substance user treatment dropout from client and clinician perspectives: A pilot study.' *Substance Use & Misuse*, 44(7), pp. 1021-1038. DOI: 10.1080/10826080802495237

Parlett, M. (1991) 'Reflections on field theory.' *The British Gestalt Journal*, 1, pp. 68-91.

Parlett, M. (1997) 'The unified field in practice.' *Gestalt Review*, 1(1), pp. 16-33.

Parlett, M. (2005) 'Contemporary gestalt therapy: field theory'. *In* Woldt, A. and Toman, S. (eds.) *Gestalt therapy: history, theory and practice*, London: Sage Publications Ltd., pp. 41-65.

Patkar, A.A., Thornton, C.C., Mannelli, P., Hill, K.P., Gottheil, E., Vergare, M.J. and Weinstein, S.R. (2004) 'Comparison of pretreatment characteristics and treatment outcomes for alcohol -, cocaine-, and multisubstance-dependent patients.' *Journal of Addictive Disease*, 23(1), pp. 93-109. DOI: 10.1300/j069v23n01_08.

Patton, M.Q. (2002) *Qualitative research and evaluation methods*. 3rd ed., London: Sage Publications Ltd.

Pearlman, L. A. and Saakvitne, K. W. (1995) *Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W W Norton & Co.

Peng, C.J. (2017) 'Logistic Regression'. *In* Wyse, D., Selwyn, N., Smith, E., and Suter, L.E. (eds.) *The Bera/Sage handbook of educational research*, London: Sage Publications Ltd., pp. 873-894

Perkins, E.B. and Sprang, G. (2013) 'Results from the Pro-QOL-IV for substance abuse counsellors working with offenders.' *International Journal Mental Health Addiction*, 11(2), 199-213. DOI: 10.1007/s11469-012-9412-3

Perls, F., Hefferline, R.F. and Goodman, P. (1951) *Gestalt therapy: excitement and growth in the human personality*. London: Souvenir Press.

Perron, N. J., Dao, M.D., Righini, N,C., Humair, J.P., Broers, B., Narring, F., Haller, D.M. and Gaspoz, J.M. (2013) 'Text-messaging versus telephone reminders to reduce missed appointments in an academic primary care clinic: A randomized controlled trial.' *BMC Health Services Research*, 13(1), 125. [Online] [Accessed on 5th March 2018] DOI: 10.1186/1472-6963-13-125

PHE (2016) *Health matters: harmful drinking and alcohol dependence.* [Online] [Accessed on 9th April 2018] https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

PHE (2019) *National statistics: young people's substance misuse treatment statistics 2018 to 2019*. [Online] [Accessed on 23rd Oct 2020] https://www.gov.uk/government/publications/substance-misuse-treatment-for-young-people-statistics-2018-to-2019/young-peoples-substance-misuse-treatment-statistics-2018-to-2019-report

Plano Clark, V.L. and Creswell, J.W. (2008) *The mixed methods reader*. London: Sage Publications Ltd.

Polit, D.F. and Beck, C.T. (2010) 'Generalization in quantitative and qualitative research: myths and strategies.' *International Journal of Nursing Studies*, 47(11) pp. 1451-1458. DOI: 10.1016/j.ijnurstu.2010.06.004.

Polkinghorne, D. E. (2005) 'Language and meaning: Data collection in qualitative research.' *Journal of Counseling Psychology,* 52(2), pp. 137-145. DOI: 10.1037/0022-0167.52.2.137

Poll, R., Allmark, P. and Tod, A. M. (2017) 'Reasons for missed appointments with a hepatitis C outreach clinic: A qualitative study.' *International Journal of Drug Policy*, 39, pp. 130-137. [Online] [Accessed on 12th July 2019] DOI: https://doi.org/10.1016/j.drugpo.2015.12.027

Prisciandaro, J.J., Rembold, J., Brown, D.G., Brady, K.T. and Tolliver, B.K. (2011) 'Predictors of clinical trial dropout in individuals with co-occurring bipolar disorder and alcohol dependence.' *Drug and Alcohol Dependence,* 118(2), pp. 493-496. DOI: 10.1016/j.drugalcdep.2011.03.029

Prochaska, J. O., and DiClemente, C. C. (1983) Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), pp. 390 –395. DOI: 10.1037/0022-006X.51.3.390

Project MATCH Research Group (1997) Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol,* 58(1), pp. 7-29. DOI: 10.15288/jsa.1997.58.7

Pulford, J., Adams, P. and Sheridan, J. (2010) 'Responding to treatment dropout: A review of controlled trials and suggested future directions.' Addiction Research & Theory, 18(3), pp. 298-315. DOI: 10.3109/16066350903151385

Qur'an - Abdel Haleem, M. A. S. (translator) (2010) *The Qurʾan: English translation and parallel Arabic text*. Oxford: Oxford University Press.

Robine, J. (2013) 'Shame.' *In* Francesetti, G., Gecele, M. and Roubal, J. (eds.) *Gestalt therapy in clinical practice: from psychopathology to the aesthetics of contact*. Itlay: Istituto di Gestalt HCC. [Kindle Version].

Robinson, O. C. (2014) 'Sampling in interview-based qualitative research: A theoretical and practical guide.' *Qualitative Research in Psychology*, 11(1), pp. 25-41. DOI: 10.1080/14780887.2013.801543

Robotham, D., Satkunanathan, S., Reynolds, J., Stahl, D. and Wykes, T. (2016) 'Using digital notifications to improve attendance in clinic: systematic review and meta-analysis.' *BMJ Open*, 6(10), e012116. [Online] [Accessed on 10th December 2018] DOI: 10.1136/bmjopen-2016-012116

Rogers, C. R. (1959) 'A theory of therapy, personality, and interpersonal relationships as developed in the client-centred framework.' *In* Koch, S. (ed.) *Psychology: A study of a science,* New York: McGraw Hill, pp. 184-256

Rogers, C.R. (1957) The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), pp. 95–103. https://doi.org/10.1037/h0045357

Rogers, C.R. (1980) *A way of being*. Boston, MA: Houghton Mifflin.

Ronzitti, S., Soldini, E., Smith, N., Clerici, M. and Bowden-Jones, H. (2017) 'Gambling disorder: Exploring pre-treatment and in-patient dropout predictors. A UK study.' *The Journal of Gambling Studies*, 33 (4), pp. 1277-1292. DOI: 10.1007/s10899-017-9686-2

Rosenzweig, S. (2002). 'Some implicit common factors in diverse methods of psychotherapy.' *Journal of Psychotherapy Integration,* 12(1), pp. 5-9. DOI: 10.1037/1053-0479.12.1.5

Roy, A. and Buchanan, J. (2016) 'The paradoxes of recovery policy: Exploring the impact of austerity and responsibilisation for the citizenship claims of people with drug problems.' *Social Policy & Administration*, 50(3), pp. 398-413. DOI: 10.111/spol.12139

Rozemond, M. (2002) *Descartes's dualism*. USA: Harvard University Press

Ryde, J. (2009) *Being White in the helping professions: developing effective intercultural awareness.* London: Jessica Kingsley Publishers.

Sanders, R. and Lehmann, J. (2019) 'An exploratory study of clients' experiences and preferences for counselling room space and design.' Counselling and Psychotherapy Research, (19), pp. 57-65. https://doi-org.mmu.idm.oclc.org/10.1002/capr.12202

Sandhu, J.S. (2009) 'A Sikh perspective on alcohol and drugs: Implications for the treatment of Punjabi-Sikh patients.' *Sikh Formations*, 5(1), 23-37. DOI: 10.1080/17448720902935037

Saunders, M.N.K. (2012) 'Choosing research participants.' *In* Symon, G. and Cassell, C. (eds.) *Qualitative organization research: core methods and current challenges*, London: Sage Publications Ltd., pp. 35-52.

Scatliffe, N., Casavant, S., Vittner, D. and Cong, X. (2019) 'Oxytocin and early parent-infant interactions: a systematic review.' *Internal Journal of Nursing Sciences*, 6(4), pp. 445-453. DOI: 10.1016/j.ijnss.2019.09.009.

Schroder, R.N., Sellman, J.D., and Deering, D. (2007) 'Improving Addiction Treatment Retention for Young People: A Research Report from the National Addiction Centre'. *Alcohol Advisory Council of New Zealand.* ISBN: 978-1-877373-37-4

Schroder, R.N., Sellman, J.D., Frampton, C., and Deering, D. (2009) 'Youth retention: factors associated with treatment drop-out from youth alcohol and other drug treatment. Drug and Alcohol Review, 28, pp. 663-668. https://doi-org.mmu.idm.oclc.org/10.1111/j.1465-3362.2009.00076.x

Schwartz, B.M., Wilson, J.H. and Goff, D.M. (2015) *An easy guide to research design & SPSS.* London: Sage Publications Ltd.

Sebastian, F., Mushtaq, S., Easow J.M. and Luty J. (2012) 'Number needed to treat further engaged of opioid-dependent clients following missed appointments.' *Journal of Substance Use*, 17(3), pp. 235-239. DOI: 10.3109/14659891.2011.565108

Sheeran, P., Aubrey, R. and Kellett, S. (2007) 'Increasing attendance for psychotherapy: Implementation intentions and the self-regulation of attendance-related negative affect.' *Journal of Consulting and Clinical Psychology*, 75(6), pp. 853-863. DOI: 10.1037/0022-006X.75.6.853

Siqueland, L., Crits-Christoph, P., Frank, A., Daley, D., Weiss, R., Chittams, J. and Luborsky, L. (1998) 'Predictors of dropout from psychosocial treatment of cocaine dependence.' *Drug and Alcohol Dependence*, 52(1), pp. 1-13. DOI: 10.1016/S0376-8716(98)00039-8

Skills for Health (2014) *Drugs and Alcohol National Occupational Standards Review Project*. [Online] [Accessed on 12th November 2017] https://www.skillsforhealth.org.uk/resources/service-area/19-alcohol-drugs

Skog, O.J. (2000) 'Addicts' choice.' *Addictions*, 95(9), pp. 1309-1314. DOI: 10.1046/j.1360-0443.2000.95913091.x

Slawson, N. (2018) *Patients missing their appointments cost the NHS £1bn last year.* [Online] [Accessed on 2nd January 2019] www.theguardian.com/society/2018/jan/02/patients-missing-their-appointments-cost-the-nhs-1bn-last-year

Smeden, M.V., Moons, K, G.M., Groot, J.A.H., Collins, G.S., Altman, D.G., Eijkemams, M.J.C., and Reitsma, J.B. (2019) 'Sample size for binary logistic prediction models: beyond events per variable criteria'. Statistical Methods in Medical Research, 28(8), pp. 2455-2474. DOI: 10.1177/0962280218784726

Smith, A. K., Ayanian, J. Z., Covinsky, K. E., Landon, B. E., McCarthy, E. P., Wee, C. C. and Steinman, M. A. (2011). 'Conducting high-value secondary dataset analysis: an introductory guide and resources.' *Journal of General Internal Medicine*, 26(8), pp. 920-929. DOI: 10.1007/s11606-010-1621-5

Smith, J. A. (ed.) (2008) *Qualitative psychology: A practical guide to research methods.* 3rd ed., London: Sage Publications Ltd.

Smith, J., Flowers, B. and Larkin, M. (2009) *Doing interpretative phenomenological analysis*. London: Sage Publications Ltd.

Solomon, R.L. (1980) 'The opponent-process theory of acquired motivation: the costs of pleasure and the benefits pf pain.' *The American Psychologist*, 35(8), pp. 691-712. DOI: 10.1037//0003-066x.35.8.691

Sparr, L., Moffitt, M.C. and Ward, M.F. (1993) 'Missed psychiatric appointments: Who returns and who stays away.' *American Journal of Psychiatry*, 150(5), pp. 801-805. DOI: 10.1176/ajp.150.5.801

Spinelli, E. (2005) *The interpreted world: an introduction to phenomenological psychology*. 2nd ed., London: Sage Publications Ltd.

Sprang, G., Clark, J. J. and Whitt-Woosley, A. (2007) 'Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life.' *Journal of Loss and Trauma*, 12(3), pp. 259-280. DOI: 10.1080/15325020701238093

Squier, R. W. (1990) 'A model of empathic understanding and adherence to treatment regimens in practitioner-patient relationships.' *Social Science & Medicine,* 30(3), pp. 325-339. DOI: 10.1016/0277-9536(90)90188-X

Stark, M.J. (1992) 'Dropping out of substance abuse treatment: A clinically oriented review.' *Clinical Psychology Review*, 12(1), pp. 93-116. DOI: 10.1016/0272-7358(92)90092-M

Stasiewicz, P.R. and Stalker, R. (1999) Brief report a comparison of three interventions on pretreatment dropout rates in an outpatient substance abuse clinic. Addictive Behaviors, 24 (4), pp. 579-782. DOI: 10.1016/S0306-4603(98)00082-3

Stewart, I. (2013) *Transactional analysis counselling in action*. 4th ed., London: Sage Publications Ltd.

Stoffelmayr, B., Mavis, B., Sherry, L. and Chiu, C. (1999) 'The influence of recovery status and education on addiction counselors' approach to treatment.' *Journal of Psychoactive Drugs*, 31(2), pp. 121-127. DOI: 10.1080/02791072.1999.10471734.

Sullivan, E.V., Rosenbloom, M.J., Lim, K.O. and Pfefferbaum, A. (2000) 'Longitudinal changes in cognition, gait, and balance in abstinent and relapsed alcoholic men: Relationships to changes in brain structure.' *Neuropsychology*, 14(2), pp. 178-188. DOI: 10.1037/0894-4105.14.2.178.

Sussman, S. and Sussman, A.N. (2011) 'Considering the definition of addiction.' *International Journal of Environmental Research and Public Health*, 8 (10), pp. 4025-4038. DOI: 10.3390/ijerph8104025.

Szczepura, A. (2005) 'Access to health care for ethnic minority populations.' *Postgraduate Medical Journal*, 81(953), pp. 141-147. DOI: 10.1136/pgmj.2004.026237

Tabachnick, B. G. and Fidell, L. S. (2001) *Using multivariate statistics.* 4th ed., Essex: Pearson Education Limited.

Tashakkori, A. and Teddlie, C. (2003) *Handbook of mixed methods in social & behavioral research*. London: Sage Publications Ltd.

Teddlie, C. and Tashakkori, A. (2009) *Foundations of mixed methods research*. London: Sage Publications Ltd.

Teddlie, C. and Yu, F. (2007) 'Mixed methods sampling: A typology with examples.' *Journal of Mixed Methods Research*, 1(1), pp. 77-100. DOI: 10.1177/2345678906292430

Terra, M. B., Barros, H. M. T., Stein, A. T., Figueira, I., Athayde, L. D., Palermo, L. H. and da Silveira, D. X. (2007) 'Predictors of engagement in the alcoholics anonymous group or to psychotherapy among Brazilian alcoholics: A six-month follow-up study.' *European Archives of Psychiatry and Clinical Neuroscience*, 257(4), pp. 237-244. DOI: 10.1007/s00406-007-0719-1

The Information Centre (2012) *Statistics on alcohol*. [Online] [Accessed on 8th May 2016] http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2012-[ns]

Thompson-Miller, R. and Feagin, J.R. (2007) 'Continuing injuries of racism: counselling in a racist context.' *The Counselling Psychologist*, 35(1), 106-115. DOI: 10.1177/0011000006294664

Thorberg, F.A. and Lyvers, M. (2010) 'Attachment in relation to affect regulation and interpersonal functioning among substance use disorder in parents.' *Addiction Research & Theory*, 18(4), pp. 464-478. DOI: 10.3109/16066350903254783

Tofighi, B., Grazioli, F., Bereket, S., Grossman, E., Aphinyanaphongs, Y. and Lee, J. D. (2017) 'Text message reminders for improving patient appointment adherence in an office-based buprenorphine program: A feasibility study.' *The American Journal on Addictions*, 26(6), pp. 581-586. DOI: 10.1111/ajad.12557

Tomberg, C. (2010) 'Categories of alcohol consumers: definitions and criteria of alcohol addiction.' *Journal of Psychophysiology*, 24(4), pp. 213-214. DOI: 10.1027/0269-8803/a000034

Toriello, P. J. and Strohmer, D. C. (2004) 'Addictions counselors' credibility: The impact of interactional style, recovery status, and nonverbal behavior.' *Journal of Addictions & Offender Counseling*, 25(1), pp. 43-57. DOI: 10.1002/j.2161-1874.2004.tb00192.x

Trinh, Q. (2018) Understanding the impact and challenges of secondary data analysis. *Urological Oncology: Seminars and Original Investigations*, 36(4), pp. 163-164. DOI: 10.1016/j.urolonc.2017.11.003

Tronnier, C. D. (2015) 'Harnessing attachment in addiction treatment: Regulation theory and the self-medication hypothesis.' *Journal of Social Work Practice in the Addictions*, 15(3), pp. 233-251. DOI: 10.1080/1533256X.2015.1056529

UKATT Research Team (2005) Effectiveness of treatment for alcohol problems: findings of the randomised United Kingdom Alcohol Treatment Trial (UKATT). *British Medical Journal*, 331(7516): pp. 541-544. DOI: doi.org/10.1136/bmj.331.7516.541

UKCP (2019) UKCP Code of Ethics and Professional Practice. [Online] [Accessed on 7th January 2020] https://www.psychotherapy.org.uk/wp-content/uploads/2019/06/UKCP-Code-of-Ethics-and-Professional-Practice-2019.pdf

Vasilaki, E.I., Hosier, S.G. and Cox, M. (2006) The efficacy of motivational interviewing as a brief intervention for excessive drinking: a meta-analytic review. *Alcohol and Alcoholism*, 41(3), pp. 328-335. DOI: 10.1093/alcalc/ag1016.

Vendetti, J., McRee, B., Miller, M., Christiansen, K., Herrell, J. and The Marjuana Treatment Project Research Group (2002) 'Correlates of pre-treatment drop-out among persons with marijuana dependence.' *Society for the Study of Addiction to Alcohol and Other Drugs*, 97(1), pp. 125-134. DOI: 10.1046/j.1360-0443.97.s01.8.x

Vogel, D.L., Wester, S.R. and Larson, L.M. (2007) Avoidance of counselling: Psychological factors that inhibit seeking help. *Journal of Counseling & Development*, *85(*4), 410–422. https://doi.org/10.1002/j.1556-6678.2007.tb00609.x

Vohs, K.D. and Baumeister, R.F. (2009) 'Addiction and free will.' *Addictive Research & Theory,* 17(3), pp. 231-235. DOI: 10.1080/16066350802567103.

Walters, G.D. (1996) 'Addiction and identity: exploring the possibility of a relationship.' *Psychology of Addictive Behaviors, 10*(1), pp. 9-17. DOI: 10.1037/0893-164X.10.1.9

Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K. and Hyun-nie, A. (1997) 'A meta-analysis of outcome studies comparing boa fide psychotherapies: Empirically, "all must have prizes." ' *Psychological Bulletin*, 122(3), pp. 203-215.

Wang, M., Sandberg, J., Zavada, A., Mittal, M., Gosling, A., Rosenberg, T., Jeffrey, A., and McPheters, J. (2006) 'Almost There… Why clients fail to engage in family therapy: an

exploratory study.' *Contemporary Family Therapy*, *28*(2), pp. 211–224. DOI: 10.1007/s10591-006-9001-3

Waring, M. (2017) Finding your theoretical position. *In* Coe, R., Waring, M., Hedges, L.V., Arthur, J. (eds.) *Research Methods & Methodologies in Education.* 2nd ed., London: Sage Publications Ltd., pp. 15-22

Webb, L., Ryan, T. and Meier, P. (2008) 'Care pathways to in-patient alcohol detoxification and their effects on predictors of treatment completion.' *Journal of Substance Use*, 13(4), pp. 255-267. DOI: 10.1080/1469890801886960

Webster, S., Lewis, J. and Brown, A. (2003) 'Ethical considerations in qualitative research.' *In* Ritchie, J., Lewis, J., Nicholls, C.M., and Ormston, R. (eds.) *Qualitative research practice: A guide for social science students & researchers.* London: Sage Publications Ltd., pp. 77-110.

Weisner, C., Mertens, J., Tam, T. and Moore, C. (2001) 'Factors affecting the initiation of substance abuse treatment in managed care.' *Addiction*, 96(5), pp. 705-716. DOI: 10.1080/09652140020039071

West, R. and Brown, J. (2013) *Theory of addiction*. 2nd ed., West Sussex: John Willey & Sons, Ltd.

Wheeler, G. (1997) Self and shame: a gestalt approach. *Gestalt Review*, 1(3), pp. 221-244 https://www.jstor.org/stable/44394019

Wheeler, S. and Richards, K. (2007) *The impact of clinical supervision on counsellors and therapists, their practice and their clients; a systematic review of the literature*. BACP. [Online] [Accessed on 5th June 2018] https://www.bacp.co.uk/media/1982/bacp-impact-clinical-supervision-on-counsellors-therapists-practice-and-clients-systematic-review.pdf

White, W. (2000) Addiction as a disease: birth of a concept. *Counselor*, 1(1), pp. 46-51.

White, W. (2009) 'Addiction recovery: Its definition and conceptual boundaries.' *Journal of Substance Abuse Treatment*, 33(3): pp. 229-41. DOI: 10.1016/j.jsat.2007.04.015.

WHO (1994). *Lexicon of psychiatric and mental health terms*, 2nd ed. Geneva. [Online] [Accessed on 9th May 2016] http://www.who.int/substance_abuse/ terminology/ who_lexicon/en/

Wiens, T. K. and Walker, L. J. (2015). 'The chronic disease concept of addiction: Helpful or harmful?' *Addiction Research & Theory*, 23(4), pp. 309-321. DOI: 10.3109/16066359.2014.987760

Wierzbicki, M. and Pekarik, G. (1993) 'A meta-analysis of psychotherapy dropout.' *Professional Psychology: Research and Practice,* 24(2), pp. 190-195. DOI: 10.1037/0735-7028.24.2.190

Wilkinson, S. (2008) 'Focus groups.' *In* Smith, J.A. (ed.) *Qualitative psychology: a practical guide to research methods.* 2nd ed., London: Sage Publications Ltd., pp. 186 – 206.

Willig, C. (2001) *Introducing qualitative research in psychology: adventures in theory and method*. Buckingham: Open University Press.

Wollants, G. (2012) *Gestalt therapy: therapy of the situation*. London: Sage Publications Ltd.

World Health Organisation (2016) *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*. Geneva, World Health Organization. www.who.int/classifications/icd/en/ bluebook.pdf[Online] [Accessed on 19th May 2018]

World Health Organization (2020) *Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak (developed by the IASC's Reference Group on Mental Health and Psychosocial Support).* [Online] [Accessed on 22nd September 2020] https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing

World Health Organization (n.d.) Alcohol use: data and statistics. [Online] [Accessed on 27th June 2018] https://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/data-and-statistics

Wray, N., Markovic, M., and Manderson, L. (2007) 'Researcher Saturation: the impact of data triangulation and intensive-research practices on the researcher and qualitative research process.' *Qualitative Health Research*, 17(10), pp. 1392-1402. DOI: 10.1177/1049732307308308

Wu, X., Anderson, R. C., Nguyen-Jahiel, K. and Miller, B. (2013) 'Enhancing motivation and engagement through collaborative discussion.' *Journal of Educational Psychology*, 105(3), pp. 622-632. DOI: 10.1037/a0032792

Xiao, H., Hayes, J. A., Gastonguay, L.G. and McAleavey, A.A. (2017) 'Therapist effects and the impacts of therapy nonattendance.' *Psychotherapy*, 54(1), pp. 58-65. DOI: 10.1037/pst0000103

Yardley, L. & Bishop, F. (2007) Mixing qualitative and quantitative methods: a pragmatic approach. *In* Willig, C and Wendy, S.R. (eds.) *The SAGE Handbook of Qualitative Research in Psychology. London:* Sage Publications Ltd., pp. 352-370.

Yontef, G. (2002) The relational attitude in gestalt therapy theory and practice. *International Gestalt Journal*, 25(1), pp. 15-34.

Yontef, G.M. (1993) *Awareness, dialogue and process*. Goulsboro: The Gestalt Journal Press, Inc.

Zane, N., Nagayama Hall, G.C., Sue, S., Young, K. and Nunez, J. (2004) 'Research on psychotherapy with culturally diverse populations.' *In* Lambert, M.J. (ed.) *Bergin and Garfield's handbook of psychotherapy and behavior change.* 5th ed., New York: Wiley, pp. 767-804

Zou, L.X. and Dickter, C.L. (2013) 'Perceptions of racial confrontation: the role of color blindness and comment ambiguity.' *Cultural Diversity and Ethnic Minority Psychology*, 19 (1), pp. 92-96. DOI: 10.1037/a0031115

Appendices

Appendix A	Literature search terms
Appendix B	UoB ethics approval
Appendix C	Ethics amendment applications and approvals (MMU)
Appendix D	Participant information sheets and consent forms
Appendix E	Participating organisation's approval
Appendix F	Practitioners' Interview guide
Appendix G	Post interview reflection form
Appendix H	Reflective journal example
Appendix I	Clients' – Focus group guide
Appendix J	Chi-square analysis
Appendix K	Template analysis – templates

Appendix A Literature search terms

Literature search terms

alcohol* AND support* AND appointment*
alcohol* AND pract* AND appointment*
alcohol* AND treatment* AND appointment*
alcohol* AND service* AND appointment*
alcohol* AND counsel* AND appointment*
alcohol* AND intervention* AND appointment*
alcohol* AND help* AND appointment*
drink* AND support* AND appointment*
drink* AND pract* AND appointment*
drink* AND treatment* AND appointment*
drink* AND service* AND appointment*
drink* AND counsel* AND appointment*
drink* AND intervention* AND appointment*
drink* AND help* AND appointment*
substance* AND support* AND attend*
substance* AND pract* AND attend*
substance* AND treatment* AND attend*
substance* AND service* AND attend*
substance* AND counsel* AND attend*
substance* AND intervention* AND attend*
substance* AND help* AND attend*
drug* AND support* AND attend*
drug* AND pract* AND attend*
drug* AND treatment* AND attend*
drug* AND service* AND attend*
drug* AND counsel* AND attend*
drug* AND intervention* AND attend*
drug* AND help* AND attend*
alcohol practitioner AND attendance*
alcohol worker AND attendance*
drug worker AND attendance*
substance worker AND attendance*
alcohol practitioner AND engagement*
alcohol worker AND engagement*
drug worker AND engagement*
substance worker AND engagement
alcohol* AND support* AND attend*
alcohol* AND pract* AND attend*
alcohol* AND treatment* AND attend*
alcohol* AND service* AND attend*
alcohol* AND counsel* AND attend*
alcohol* AND intervention* AND attend*
alcohol* AND help* AND attend*
drink* AND support* AND attend*
drink* AND pract* AND attend*
drink* AND treatment* AND attend*
drink* AND service* AND attend*
drink* AND counsel* AND attend*
drink* AND intervention* AND attend*
drink* AND help* AND attend*
substance* AND support* AND appointment*
substance* AND pract* AND appointment*
substance* AND treatment* AND appointment*
substance* AND service* AND appointment*
substance* AND counsel* AND appointment*
substance* AND intervention* AND appointment*
substance* AND help* AND appointment*
drug* AND support* AND appointment*
drug* AND pract* AND appointment*
drug* AND treatment* AND appointment*
drug* AND service* AND appointment*
drug* AND counsel* AND appointment*
drug* AND intervention* AND appointment*
drug* AND help* AND appointment*
alcohol practitioner AND appointment*
alcohol worker AND appointment*
drug worker AND appointment*
substance worker AND appointment*
Appointment* AND attendance*
Session* AND attendance*
Appointment* AND DNA*
Alcohol* AND DNA*
Substance* AND DNA*

Appendix B UoB ethics approval

University of Bedfordshire
Institute of Applied Social Research
Dept of Applied Social Studies
Park Square
Luton
LU1 3JU

Dear Faisal

Re: IASREC Application No: 11

Project Title: Exploring reasons for clients' non-attendance in Alcohol Misuse Community Services

The Ethics Committee of the Institute of Applied Social Research has considered your application and has decided that the proposed research project should be approved.

Please note that if it becomes necessary to make any substantive change to the research design, the sampling approach or the data collection methods a further application will be required.

If the proposed work involves users or providers of any local authority service (this includes some education, pre-school and care establishments) you will additionally need approval from the relevant Local Authority.

If the project involves users of providers of health services approval will also be required from the relevant NHS Research Ethics Committee.

Proposals relevant to Luton Borough Council's Research Governance Committee will be forwarded by IASREC on your behalf. For other councils this will be the responsibility of the researcher. In all cases **it is your responsibility to ensure that you are in possession of proof of all necessary authorisations before any fieldwork commences**.

Yours sincerely

Dr Tim Bateman
Chair IASREC

Appendix C Ethics amendment applications and approvals (MMU)

MANCHESTER METROPOLITAN UNIVERSITY
FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE

M E M O R A N D U M

FACULTY ACADEMIC ETHICS COMMITTEE

Manchester Metropolitan University

To: Faisal Mahmood

From: Prof Carol Haigh

Date: 12/08/2015

Subject: Ethics Application

Title: Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service

---

Thank you for your application for an amendment to your original ethical approval.

The Faculty Academic Ethics Committee review process has recommended approval of your amendment. This approval is granted for 42 months for full-time students or staff and 60 months for part-time students. Extensions to the approval period can be requested.

If your research changes you might need to seek ethical approval for the amendments. Please request an amendment form.

We wish you every success with your project.

Prof Carol Haigh and Prof Jois Stansfield
Chair and Deputy Chair
Faculty Academic Ethics Committee

Manchester Metropolitan
University

M E M O R A N D U M

FACULTY ACADEMIC ETHICS COMMITTEE

Faculty of Health, Psychology & Social Care

Brooks Building
Birley Fields Campus
53 Bonsall Street
Manchester
M15 6GX

+44 (0)161 247 2569

HPSCresearchdegrees@mmu.ac.uk

To: Faisal Mahmood

From: Prof Carol Haigh

Date: 20/10/2017

Subject: Ethics Application 1529

Title: Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.

Thank you for your application for a second amendment to your original ethical approval, which was granted by the University of Bedfordshire.

The Faculty Academic Ethics Committee review process has recommended approval of your amendment. This approval is granted for 42 months for full-time students or staff and 60 months for part-time students. Extensions to the approval period can be requested.

If your research changes you might need to seek ethical approval for the amendments. Please request an amendment form.

We wish you every success with your project.

Prof Carol Haigh
Chair
Faculty Academic Ethics Committee

REQUEST FOR AN AMENDMENT TO AN APPLICATION FOR ETHICAL APPROVAL PREVIOUSLY GRANTED FAVOURABLE OPINION

Manchester Metropolitan University

1. Details of Applicants	
1.1. Name of applicant (Principal Investigator): Faisal Mahmood	
Telephone Number: 07811444900	
Email address: f.mahmood@newman.ac.uk	
Status:	Postgraduate Student (~~Taught or~~ Research) ~~Staff~~
Department/School/Other Unit: Health, Psychology and Social Care	
Programme of study (if applicable): PhD	
Name of supervisor/Line manager: Dr Sarah Galvani	
1.2. Co-Workers and their role in the project: (e.g. students, external collaborators, etc)	
Name:	Name:
Telephone Number:	Telephone Number:
Role:	Role:
Email Address:	Email Address:
2. Details of the Project	
2.1. Title: Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.	
2.2. Ethical Approval number: N/A	
2.3. Describe the amendment that is requested and why. Additional sheets may be attached.	

I no longer work as an employee (service manager) at Solihull Aquarius (left Aquarius in April 2015). In my original ethical approval application (see attached) I didn't include Solihull site for qualitative study due to issues related to 'insider research'.
Due to above mentioned reason, now I'd like to include Solihull site in my study as it offers traditional and main stream addiction service as compared to Birmingham site. Aquarius lost Birmingham contract last year.
I will only include service users from Solihull site.

Please note that my original ethical application was approved by University of Bedfordshire (I transferred to MMU in Dec 2014).

2.4. Start Date / Duration of project: Jan 2013 / PhD part time

3. Ethical Issues

3.1. Please describe any ethical issues raised (you do not need to cover issues that were addressed in the initial application) and how you intend to address these:

4. Safeguards/Procedural Compliance

4.1. Insurance

The University holds insurance policies in place to cover claims for negligence arising from the conduct of the University's normal business, which includes research carried out by staff and by undergraduate and postgraduate students as part of their course. This does not extend to clinical negligence.

In addition, the University has provision to award indemnity and/or compensation in the event of claims for non-negligent harm. This is on the condition that the project is accepted by the insurers prior to the commencement of the research project and approval has been granted for the project from a suitable ethics committee.

Research which is applicable to non-negligent harm cover involves humans and physical intervention which could give rise to a physical injury or illness which is outside the participants day to day activities. This includes strenuous exercise, ingestion of substances, injection of substances, topical application of any substances, insertion of instruments, blood/tissue sampling of participants and scanning of participants.

The following types of research are not covered automatically for non-negligent harm if they are classed as the activities above and they involve:

1) Anything that assists with and /or alters the process of contraception, or investigating or participating in methods of contraception

2) Anything involving genetic engineering other than research in which the medical purpose is treating or diagnosing disease
3) Where the substance under investigation has been designed and /or manufactured by MMU
4) Pregnant women
5) Drug trials
6) Research involving children under sixteen years of age
7) Professional sports persons and or elite athletes.
8) Overseas research

Will the proposed project result in you undertaking any research that includes any of the 8 points above or would not be considered as normal University business? If so, please detail below:

SIGNATURE OF PRINCIPAL INVESTIGATOR: F.Mahmood	Date : 12.08.2015
SIGNATURE OF FACULTY'S HEAD OF ETHICS:	Date:

REQUEST FOR AN AMENDMENT TO AN APPLICATION FOR ETHICAL APPROVAL PREVIOUSLY GRANTED FAVOURABLE OPINION

Manchester Metropolitan University

5. Details of Applicants	
5.1. Name of applicant (Principal Investigator): Faisal Mahmood	
Telephone Number: 07811444900	
Email address: f.mahmood@newman.ac.uk	
Status:	Postgraduate Student (Research)
Department/School/Other Unit: Faculty of health, psychology and social care	
Programme of study (if applicable): PhD	
Name of supervisor/Line manager: Prof Sarah Galvani, Dr Cherilyn Dance, Dr Lucy Webb	
5.2. Co-Workers and their role in the project: (e.g. students, external collaborators, etc)	
Name:	Name:
Telephone Number:	Telephone Number:
Role:	Role:
Email Address:	Email Address:
6. Details of the Project	
6.1. Title: Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.	
6.2. Ethical Approval number: N/A	

6.3. Describe the amendment that is requested and why. Additional sheets may be attached.

I am seeking ethical approval to include 'focus groups' with service users as a qualitative research method in addition to one to one interviews.

I would like to collect qualitative data using service users' focus groups (Service users - who use Aquarius - Midlands based substance misuse service). My original ethics approval application only included one to one interviews with the service users and practitioners.

Please note that my original ethical application was approved by University of Bedfordshire and accepted by MMU at the RD1 stage.
(I transferred to MMU in Dec 2014).

Additional Information:

Title

Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service: clients' and practitioners' perspectives.

Aim

The main aim of this research is to gain a deeper understanding of the reasons for clients' non-attendance at appointments within a community-based alcohol service from the perspectives of clients and practitioners

Work to date

I have completed the phase 1 – quantitative study: secondary analysis of existing dataset.

I am currently working on phase 2 – qualitative study: interviewing service users and practitioners. I have completed one to one interviews with practitioners.

Rationale for using focus groups

It has been challenging to recruit service users for one to one interviews mainly due to the very nature of the study 'exploring non-attendance'. During the phase 2 (qualitative study) some practitioners have suggested that it will be logistically easier to undertake one or two 'focus group/s'.

I believe focus groups will be useful in collecting data about personal and group feelings, perceptions and opinions as well as provide a broader range of information.

A Focus Group can be helpful for providing in depth talk and interaction with multiple participants at the same time in a supportive environment (Braun and Clarke, 2006).

Recruitment

Participants will be recruited from two different Aquarius project locations – Solihull and Derby. Both projects (Solihull and/or Derby) currently run a range of therapeutic and/or community groups for their service users. I will liaise with the service managers in the first instance followed by providing an information sheet (see attached) key information with regards to my research project to the clinical staff. The practitioners / support workers will distribute and explain and seek initial verbal consent from potential participants (service users) so that they can be invited to attend a focus group. Participants will be asked to sign an informed consent form on the day of each Focus Group. Signed consent forms (see attached) will be stored separately from transcripts.

I am aiming to recruit about 4 - 8 participants for each focus group. This group size is recommended in terms of generating rich data and managing the group size (Braun and Clarke, 2006).

Following each Focus Group there will be a short debriefing session where I will check how the participants found the experience and answer any questions they may have.

Methodology

The Focus Groups will take place at Aquarius premises/satellites in their group rooms. I will facilitate/moderate the focus groups. I will use a Focus Group Topic Guide (see attached) to foster discussion. I will also include basic ground-rules to my FG guide. The Focus Groups will be audio recorded using a Dictaphone and then transcribed verbatim.

Each Focus Group will last for approximately 1 hour -1 hour 30 minutes. The Focus Group data will be transcribed verbatim by the researcher. Recordings and Transcriptions will be stored electronically in password protected and encrypted files. Hard copies of transcripts will be stored in a locked filing cabinet. Participants' names and any identifying data will be removed from the transcripts; names will be replaced with pseudonyms. The data will then be transcribed and analysed using Thematic Analysis (Braun and Clarke, 2006).

6.4. Start Date / Duration of project: Jan 2013 / PhD part time

7. Ethical Issues

7.1. Please describe any ethical issues raised (you do not need to cover issues that were addressed in the initial application) and how you intend to address these:

In addition to previously addressed ethical issues, the notion of 'confidentiality' will be different for example, as a researcher I can and will adhere to the principles of confidentiality but it cannot be guaranteed that others (participants) will too. To address this challenge I will introduce some basic ground rules before commencing the focus groups. Where I can encourage participants to be respectful of others' anonymity and confidentiality, I cannot provide absolute guarantee about the actions of the participants in relation to the group confidentiality.

8. Safeguards/Procedural Compliance

8.1. Insurance

Please complete an insurance checklist and submit with your amendment: http://www2.mmu.ac.uk/research/our-research/ethics-and-governance/ - the form can be found in the 'Forms and Guidance' section of this page.

SIGNATURE OF PRINCIPAL INVESTIGATOR: F.Mahmood	Date 18.10.2017
SIGNATURE OF FACULTY'S HEAD OF ETHICS:	Date:

Appendix D Participant information sheets and consent forms

Individual Interviews (Practitioners' Perspectives)

Interviewee ID Code: …….. Date: ……. Time:

Information Sheet & Consent Form

Research Project: Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service

Manchester Metropolitan University

This research aims to gain a deeper understanding of the reasons for clients' non-attendance of appointments within a community-based alcohol service. This research is trying to understand the sorts of things that can lead to people missing appointments and whether there is anything services can do to make it easier for people to attend.

You are invited to take part in an interview (face to face or by telephone) lasting approximately 30 to 45mins, which will be audio recorded (with your permission). However, if you don't agree to recording, I will make written notes of our conversation.

Researcher

Faisal Mahmood, PhD Candidate (Manchester Metropolitan University)

Research Supervisors

Dr. Sarah Galvani (S.Galvani@mmu.ac.uk)
Dr. Cherilyn Dance (C.Dance@mmu.ac.uk)
Dr. Lucy Webb (L.Webb@mmu.ac.uk)

Who can participate?

- Alcohol practitioners / Support workers / Senior Practitioners / Mangers
- 18+ years old
- Work with service users with alcohol issues

Please note that:

- You are not obliged to take part.
- If you do take part, you may withdraw from the study at any time up to the point of writing up the research when your data will no longer be identifiable. If you choose to withdraw from the study all data collected from you will be destroyed within 2 working days.
- You can refuse to answer any questions
- You can stop the interview at any time and/or withdraw from it.

- Records of the interview will be kept securely and will not be made available to anyone outside the research team.
- Electronic data will be stored securely on password protected and encrypted computer and/or memory stick and the data will be kept separately from your contact details.
- Everything you say in the interview will be kept confidential to the research team and any information disclosed, referenced or quoted will be anonymous.
- Limitation to confidentiality – Please be aware that I have statutory obligation to breach confidentiality, if I believe that there is a risk of significant harm to you or someone else. By law, I will have to disclose certain information in the following situations;
  - Drug trafficking & serious crime, Terrorism
  - Safeguarding – children & vulnerable adults
  - When required by court
- All recordings will be destroyed once their transcriptions have been verified.
- All transcriptions will be destroyed within 2 years of successful completion of the PhD.

You are welcome to ask questions about the study at any time. You can contact me:

☎ 07811 444900 @ faisal.mahmood2@stu.mmu.ac.uk

If you would like to give any feedback about my work you can contact my research supervisors via their emails given above.

Please sign below to show that you have read, or I have read to you, the contents of this information sheet and consent form and that you agree to take part in this research. Alternatively you can return this form electronically with an email stating your consent to take part.

Dissemination of the findings

I would like to receive a summary report of the research study when available.	☐Yes ☐No
If yes, please specify how would you like to receive the information?	☐Post ☐Email
Postal Address:	
Email Address:	

Name: …… Date: …….

Signature: ……..

Focus Group (Clients' Perspectives)

F.G. Code: …….. Date: ……. Time: ……

Information Sheet & Consent Form (FG)

Research Project: Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service

Manchester Metropolitan University

This research aims to gain a deeper understanding of the reasons for clients' non-attendance of appointments within a community-based alcohol service. This research is trying to understand the sorts of things that can lead to people missing appointments and whether there is anything services can do to make it easier for people to attend.

You are invited to take part in a Focus Group lasting approximately 1 hour to $1_{1/2}$ hour, which will be audio recorded (with your permission). All recordings will be destroyed once the transcriptions are verified. You will also be asked to complete a very brief questionnaire at the start of Focus Group.

Researcher

Faisal Mahmood PhD student (Manchester Metropolitan University)

Research Supervisors

Prof. Sarah Galvani (S.Galvani@mmu.ac.uk)
Dr. Cherilyn Dance (C.Dance@mmu.ac.uk)
Dr. Lucy Webb (L.Webb@mmu.ac.uk)

Who can participate?

- Anyone 18 or over who has
  - experienced alcohol misuse issues at some point in your life
  - experience of some kind of treatment for alcohol misuse - either one-to-one or group counselling/work

Please note that:

- You are not obliged to take part.
- If you do take part, you may withdraw from the study at any time up to the point of writing up the research when your data will no longer be identifiable. As it is difficult to identify particular participants in the recording of a focus group, it cannot be guaranteed that all of your data can be removed; only particular sections could be excluded if identified.

- You can refuse to answer any questions
- You can withdraw from the Focus Group at any time.
- Recordings of the Focus Group will be kept securely and will not be made available to anyone outside the research team.
- Electronic data will be stored securely on password protected and encrypted computer and/or memory stick.
- Everything you say in the Focus Group will be kept confidential to the research team and any information disclosed, referenced or quoted will be anonymous.
- Limitation to confidentiality – Please be aware that I have statutory obligation to breach confidentiality, if I believe that there is a risk of significant harm to you or someone else.
- All recordings will be destroyed once the transcriptions are verified.

You are welcome to ask questions about the study at any time. You can contact me:
faisal.mahmood2@stu.mmu.ac.uk

If you would like to give any feedback about my work you can contact my research supervisors via their emails given above.

Please sign below to show that you have read or I have read to you, the contents of this information sheet and consent form and that you agree to take part in this research. Alternatively you can return this form electronically with an email stating your consent to take part.

Dissemination of the findings

I would like to receive a summary report of the research study when available.	☐Yes ☐No
If yes, please specify how would you like to receive the information?	☐Post ☐Email
Postal Address:	
Email Address:	

Name: …… Date: …….

Signature: ……..

Appendix E Participating organisation's approval

Head Office: 2nd Floor, 16 Kent Street, Birmingham B5 6RD
Tel: 0121 622 8181 Fax: 0121 622 8189
headoffice@aquarius.org.uk
www.aquarius.org.uk

AQUARIUS

7th November 2010

[redacted]

Dear Faisal,

Aquarius agrees to let you use anonymous client data and gives you permission to interview clients and practitioners with their explicit consent for research purposes, subject to University of Bedfordshire's ethics committee's approval.

If, during your interviews with clients or members of staff, a concerning issue is raised please advise the interviewee to use the appropriate Aquarius policy to raise these concerns formally. We would welcome any feedback about concerns and issues raised as part of your research.

We would also like an acknowledgement for our support in your thesis.

We wish you all the best for this very interesting piece of research and we look forward to learning how to improve our practice.

Yours sincerely,

Tonia Clark
Information Governance Lead

Appendix F Practitioners' Interview guide

V. 5

Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.

PRACTITIONER INTERVIEW GUIDE

Research questions

Exploratory interview research questions:

- What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service in *practitioners' views?
- How do practitioners experience their clients' non-attendance – exploring their (practitioners) thoughts, feelings, interpretations and behaviours?
- What do practitioners think will improve their clients' attendance?'

*practitioners/ workforce / personnel

Checklist of points for clarification before an interview

- Introduction to researcher
- Study topic - *Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.*
- Aims and objectives of the study
- Confidentiality & anonymity, right to withdraw and limitations to retrospective withdrawal
- Recording
- Length and nature of discussion/interview
- Consent form

Interview Guide

Clarification points: *Non- attendance = DNA (Did not attend) not included cancellations*

Attendance = 1:1 sessions

YOUR ROLE AND EXPERIENCE OF NON-ATTENDANCE

1. What is your current role at Aquarius / SIAS?
    a. Level of direct client contact? (1:1, group work, drop ins)

2. How long have you been working for Aquarius / SIAS?
    a. How long have you been working in the substance misuse field?

3. Aquarius data suggest that there was approximately 25% DNA rate in Aquarius/SIAS, Does that fit with your experience?

4. Current evidence suggests that certain client groups are more like to not attend such as;
    a. Younger clients (18-24)
    b. Unemployed clients
    c. High risk clients – as per Aquarius risk assessment
    d. Ethnic minority clients

    4a. Do these findings fit with your experience?
    4b. Why do you think DNA might be greater for those groups?

5. What are the common reasons for clients' non-attendance that clients report to you?

6. In your views, what are the main reasons for clients' non-attendance?
    a. Are there different patterns of non-attendance?
        i. Certain stages of their treatment/recovery?
        ii. During relapse

IMPACT AND IMPLICATIONS OF CLIENTS' NON-ATTENDANCE

7. What is it like for you when your clients don't turn up?
    a. How do you feel?

b. What goes on in your mind about why they haven't turned up?
c. Do you ever feel relieved that clients don't turn up? Why?

8. What do you do when your clients don't turn up?
    a. How do you follow up with clients?
    b. How do you spend that time?

9. In your views, what are the implications of non-attendance on clients' recovery?

10. Do you feel your 'practitioner-client' relationship is linked with your clients' attendance?
    In what ways?
        10a. What kind of factors impact on a practitioner-client relationship?

11. From your perspective, what steps have been taken by Aquarius/SIAS to reduce clients' non-attendance?
    a. What have you found most helpful and least helpful? why?
    b. Good practice examples?

12. What more could be done to further improve clients' attendance?
    12a. By the organisation?
    12b. By you?
    12c. What needs to be in place to make those changes happen?

13. Is there anything you would like add to regarding issues linked with attendance and non-attendance?

14. Is it okay for me to get in touch with you again for any clarification if needed?

Thank you very much for your help

Participant ID: ……

Basic Demographic Form

Some questions about you

Thank you for taking part in my research, I'd like to record some basic information about you. All information provided is anonymous.

Age:	☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+ ☐ Not stated
Gender:	☐ Male ☐ Female ☐ Other (Specify) ☐ Not stated
Ethnicity:	☐ White – British ☐ White – Irish ☐ White – Other ☐ Mixed – White & Black African/Caribbean ☐ Mixed – White & Asian ☐ Asian or Asian British – Indian ☐ Asian or Asian British – Pakistani ☐ Asian or Asian British – Bangladeshi ☐ Black or Black British –Africa/ Caribbean ☐ Other Ethnic Group …….. ☐ Not stated
Please choose a pseudonym	…… (In order to conceal your identity a fictitious name will be used when writing up this study.)

Appendix G **Post interview reflection form**

Reflective notes

(to be completed after the interview)

Interviewee ID code: ……Interview date: …….

1. How did the interviewee appear to me?

2. Motivation to take part

3. Presentation: gesturers, eye contact, non-verbal information

4. The 3 main points that the interviewee made

   1.

   2.

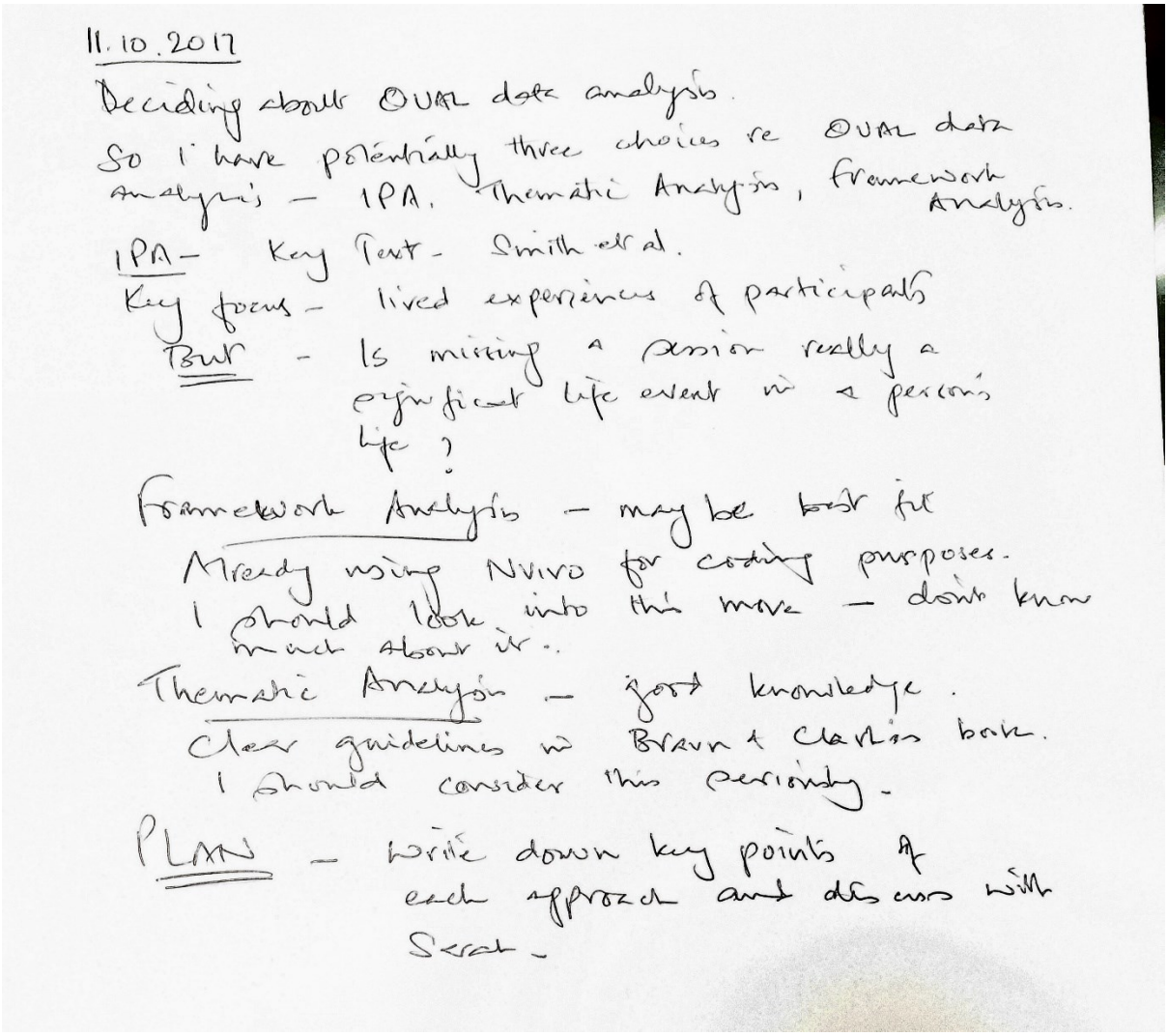
   3.

5. Any other comments

Interviewer: ……. Date: ……..

Adapted from - http://atlasti.com/data-collection/

Appendix H Reflective journal example



11.10.2017

Deciding about QUAL data analysis.

So I have potentially three choices re QUAL data analysis – IPA. Thematic Analysis, Framework Analysis.

IPA – Key Text - Smith et al.

Key focus – lived experiences of participants

But – Is missing a session really a significant life event in a person's life?

Framework Analysis – may be best fit

Already using NVivo for coding purposes.

I should look into this more – don't know much about it.

Thematic Analysis – good knowledge.

Clear guidelines in Braun & Clarke book.

I should consider this seriously.

PLAN – write down key points of each approach and discuss with Sarah.

21/11/2016

just received Sarah's feedback today re Methodology chapter. Hundreds of comments ....
I can't even read them – it's really overwhelming.
I AM FEELING OVERWHELMED !!!
Was there anything useful?
I can't do this phd. Do I even need to?
There are so many therapists who haven't got phd.
Am I still interested in topic?
I think I'm bored of it! Shall I change my topic? I can start again
I don't even understand what S is asking me to do
I think I should discuss with her.

Plan

- take a break from phd – 2-3 weeks.
- Start fresh next month
- arrange a meeting with S
- Coffee + Chat with Kevin - talk about his phd experiences
- I should block my Tuesdays for phd work only – I'm not using my phd time effectively.

Appendix I Clients' – Focus group guide

V.4

Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.

Research questions

Exploratory interview research questions:

- What are the main reasons for clients' non-attendance of appointments within a community-based alcohol service?
- How do clients make sense of their 'non-attendance' – exploring their thoughts, feelings, interpretations and behaviours?
- What features do clients suggest may improve their attendance?

Checklist of points for clarification before an interview

- Introduction to researcher
- Study topic - *Exploring reasons for clients' non-attendance of appointments within a community-based alcohol service.*
- Aims of the study
- Ground Rules
    - Confidentiality & anonymity, right to withdraw and limitations to retrospective withdrawal
- Recording
- Length and nature of the FG
- Consent forms

Focus Group Guide

Ground Rules

- The discussion should take approximately one hour to one and half an hour.
- Mobile phones switched off (or silent)
- Try to talk to each other, instead of answering the moderator
- No right or wrong answers, feel welcome to share your experiences and viewpoints
- It's OK to agree or disagree with each other, however please do so in a respectful manner.
- One person at a time – avoid talking over each other
- I (moderator) may interrupt the group discussion if these ground-ruled are not being followed.
- I may intervene in order to keep the discussion on track and to support a lively and productive discussion.
- Confidentiality

FG Guide:

As you know I am interested in talking with people who have personal experiences of alcohol misuse. I'm interested in hearing about your views and experiences in relation to non-attendance at appointments with practitioners/support workers.

- In your experience what are some of the reasons that people might miss sessions?

- Has anyone here missed an appointment without rearranging it?

- What is it like to miss an appointment?
    - Feelings, thoughts, experiences

- In your experience, how important is the relationship with the practitioner to people's attendance?
    - Can you give me some examples of what practitioners do that is helpful? Or unhelpful?
    - Are there particular characteristics of practitioners that make it easier to form a good relationship?
        - Age, gender, race, personal experiences of addiction

- Tell me what motivates you to attend your sessions?
    - What might help people to attend their appointments?

- And what motivates you to not attend your sessions?

- What do you think about the overall service Aquarius offers? Such as in relation to Staff, Environment, Location, Communication (letters, phone calls, texts).
    - In your experience, are these things linked with people's motivation to attend sessions?
    - How can the service be improved to help clients further?

- Is there anything you would like to add regarding issues linked with attendance and non-attendance?

- Is there anything you would like to ask me?

Thank you very much for your help!

Basic Demographic Form

Some questions about you

Thank you for taking part in my research, I'd like to record some basic information about you. All information provided is anonymous.

Age:	☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+ ☐ Not stated
Gender:	☐ Male ☐ Female ☐ Other (Specify) ☐ Not stated
Ethnicity:	☐ White – British ☐ White – Irish ☐ White – Other ☐ Mixed – White & Black African/Caribbean ☐ Mixed – White & Asian ☐ Asian or Asian British – Indian ☐ Asian or Asian British – Pakistani ☐ Asian or Asian British – Bangladeshi ☐ Black or Black British –Africa/ Caribbean ☐ Other Ethnic Group …….. ☐ Not stated
Religion	☐ No religion ☐ Christian ☐ Buddhist ☐ Hindu ☐ Jewish ☐ Muslim ☐ Sikh ☐ Other religion (specify) …… ☐ Not stated

Employment Status:	☐ Regular Employment ☐ Unemployed ☐ Unemployed and Seeking Work ☐ Unpaid Voluntary Work ☐ Homemaker ☐ Long Term Sick/Disabled ☐ Pupil/Student ☐ Retired from Paid Work ☐ Other……. ☐ Not stated
Accommodation Type:	☐ Social housing ☐ Private rented property ☐ Property owner ☐ Living in care ☐ Living with relatives/friends ☐ Supported housing ☐ Hostel ☐ Other …… ☐ Not stated
Relationship Status:	☐ Married ☐ Civil Partnership ☐ Single ☐ Separated ☐ Divorced ☐ Windowed ☐ Other …… ☐ Not stated

Appendix J

Chi Square Analysis

The chi square analysis was used for descriptive information only. The p value for the chi square tables is showing the significance between the DNA and attendance variable rather than the relationship between the independent variables. But the breakdown of individual variables across the two outcomes is giving descriptive information.

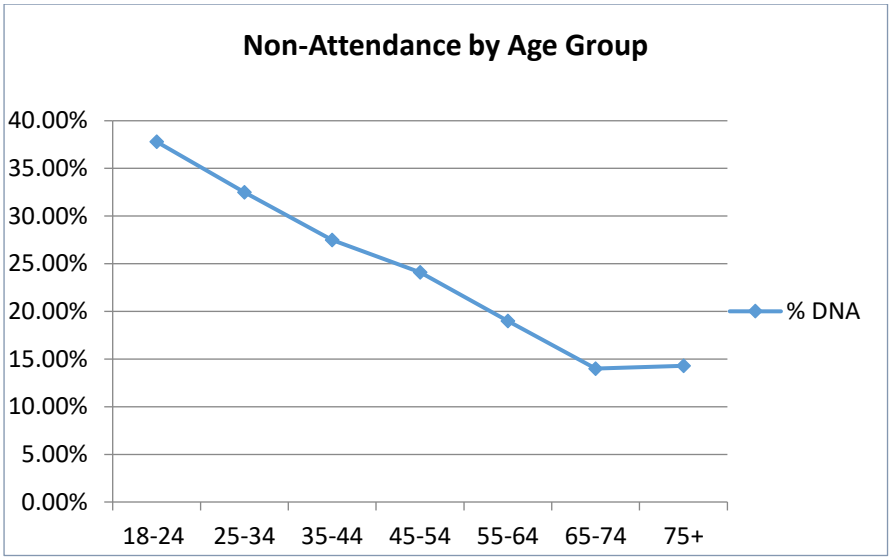
5.1 Age Group

Chi-square (X^2) analysis was performed to assess the relationship between age and non-attendance. Table 5.1 shows a summary of the results for each age group. The youngest age group were significantly more likely to not attend for treatment (37.8%), compared with all other age groups X^2 (6) = 2323.921, p<.001. The age groups most likely to attend were 55-64 years and 65-74 years old.

Table 5.1 Attendance/Non-attendance (DNA) by Age group

Age Group (years)	**Attendance Type**				
	Attended		**Non-attendance (DNA)**		
	Number	**% Attended**	**Number**	**% DNA**	**Total**
18-24	6091	62.20%	3708	37.80%	9799
25-34	25128	67.50%	12092	32.50%	37220
35-44	36541	72.50%	13866	27.50%	50407
45-54	32410	75.90%	10289	24.10%	42699
55-64	13386	81.00%	3146	19.00%	16532
65-74	3790	86.00%	619	14.00%	4409
75+	813	85.70%	136	14.30%	949
Total	**118159**		**43856**		**162015**
Total %	**72.93%**		**27.07%**		**100%**

$X^2(6) = 2323.921$, p<.001



The above graph demonstrates that younger clients were more like to DNA and with the increase in age the likelihood of attendance increases too.

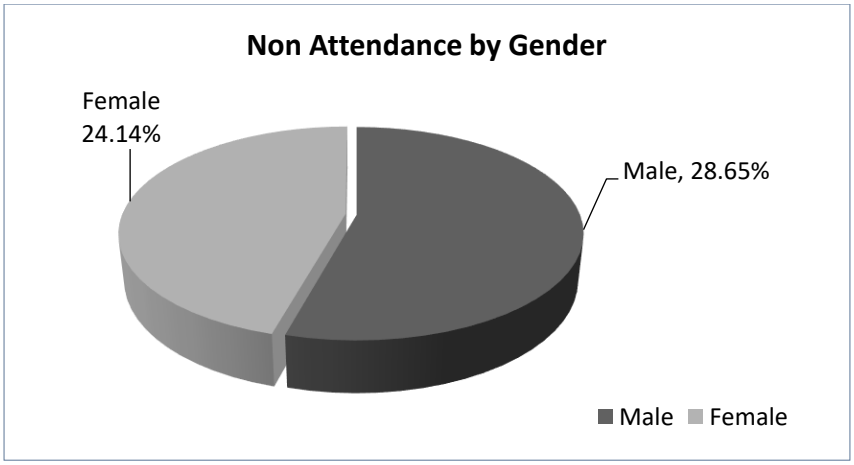
5.2 Gender

Chi-square analysis revealed a significant relationship between non-attendance and gender (Table 5.2), with males significantly more likely to not attend (28.6%), compared with female non-attenders (24.1%), $X^2(1) = 389.078$, $p<.001$.

Table 5.2 Attendance/Non-attendance (DNA) by Gender

Gender	Attendance Type				Total
	Attendance		Non-attendance (DNA)		
	Number	% Attended	Number	% DNA	
Male	75341	71.35	30251	28.65	105592
Female	44649	75.86	14210	24.14	58859
Total	**119990**		**44461**		**164451**
Total %	**72.96%**		**27.04%**		**100%**

$X^2(1) = 389.078$, $p<.001$



The above graph demonstrates that male clients were more like to DNA compared to females.

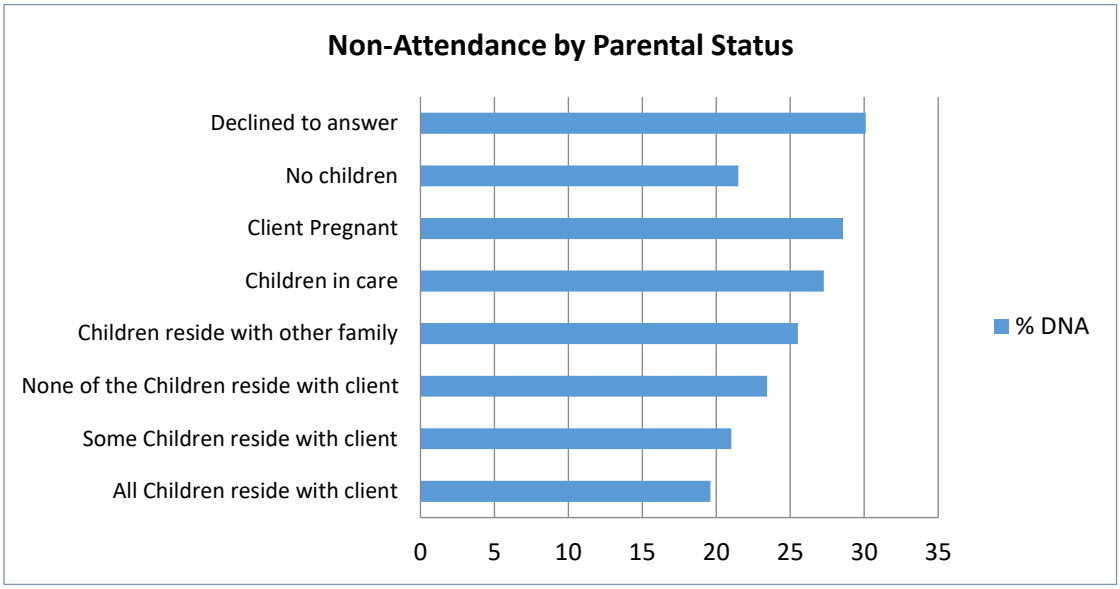
5.3 Parental Status

There was a significant relationship between non-attendance and parental status (Table 5.3). The group most likely to not attend were those who 'declined to answer' (30.1%), followed by clients who were pregnant (28.6%), then clients who had children in care (27.3%), or children residing with other family members (25.5%). Each of these parental status groups were more than 25% likely to not attend compared to other parental status groups. In contrast, the group most likely to attend had 'all children reside with them' (80.4% attendance), $X^2(7) = 169.452$, $p<.001$.

Table 5.3 Attendance/Non-attendance (DNA) by Parental Status

Parental Status	**Attendance Type**				**Total**
	Attendance		**Non-attendance (DNA)**		
	Number	**%**	**Number**	**% DNA**	
All Children reside with client	18438	80.39	4497	19.61	22935
Some Children reside with client	5522	78.98	1469	21.02	6991
None of the Children reside with client	41103	76.57	12574	23.43	53677
Children reside with other family	250	74.48	86	25.52	336
Children in care	63	72.73	24	27.27	87
Client Pregnant	11	71.43	6	28.57	17
No children	40963	78.51	11214	21.49	52177
Declined to answer	253	69.89	109	30.11	362
Total	**106603**		**29979**		**136582**
Total %	**78.05%**		**21.95%**		**100%**

$X^2(7) = 169.452$, $p<.001$



The above graph demonstrates that clients who 'declined to answer' were more likely to DNA followed by clients who were pregnant.

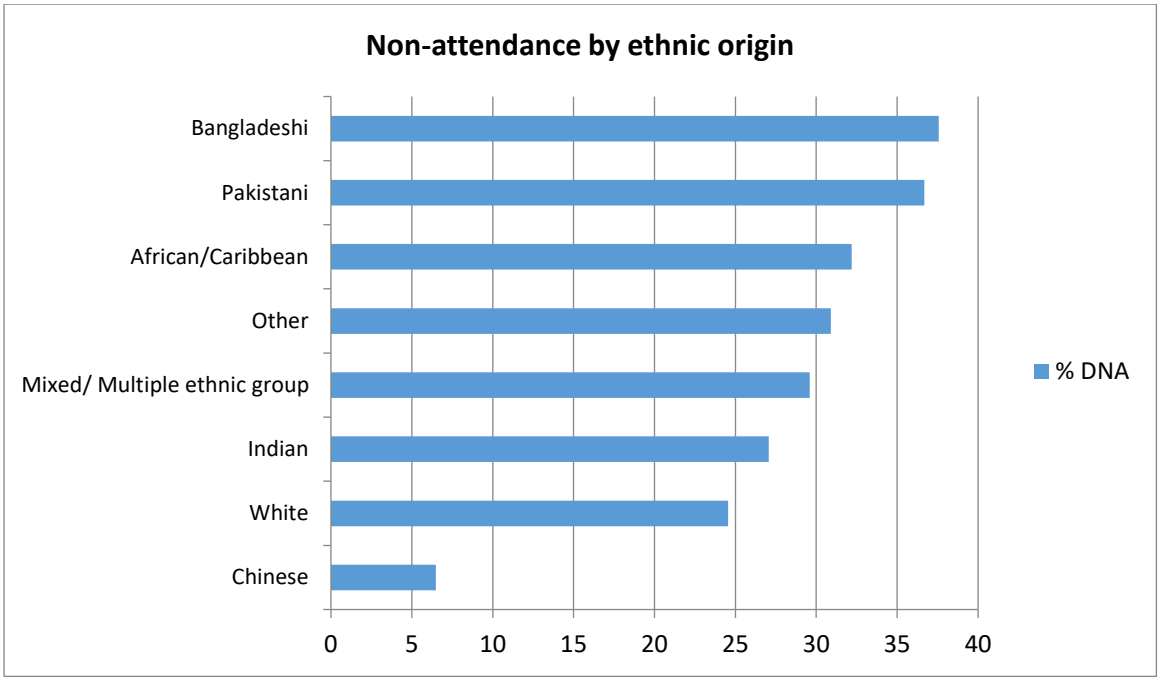
5.4 Ethnic Origin

Chi-square analysis revealed a significant relationship between non-attendance and ethnic origin of the client. The crosstab results in Table 5.4 show that the Chinese clients were least likely to not attend (6.5%), White British were second least likely to not attend (24.5%), whereas the Bangladeshi clients and Pakistani clients were the two ethnic groups most likely to not attend for treatment (37.6% and 36.7%, respectively), $X^2(7) = 403.060$, $p<.001$.

Table 5.4 Attendance/Non-attendance (DNA) by Ethnic Origin

Ethnicity	Attendance Type				Total
	Attendance		Non-Attendance (DNA)		
	Number	%	Number	% DNA	
African/Caribbean	2465	67.81	1170	32.19	3635
Bangladeshi	128	62.44	77	37.56	205
Pakistani	1003	63.32	581	36.68	1584
Indian	4419	72.93	1640	27.07	6059
Chinese	72	93.51	5	6.49	77
Mixed/ Multiple ethnic group	3173	70.4	1334	29.6	4507
White	99823	75.46	32460	24.54	132283
Other	3245	69.1	1451	30.9	4696
Total	**114328**		**38718**		**153046**
Total %	**74.70%**		**25.30%**		**100%**

$X^2(7) = 403.060$, p<.001



The above graph demonstrates that Bangladeshi and Pakistani ethnic origin clients were more likely to DNA.

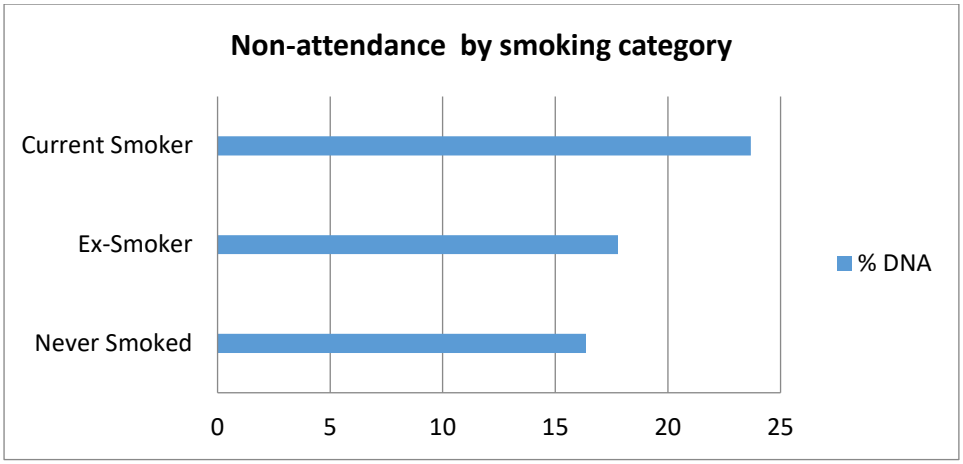
5.5 Smoking

There was a significant relationship found between non-attendance and smoking status of clients. The crosstab results in Table 5.5 shows that current smokers were most likely to not attend (23.7%), whereas the 'never smoked' and 'ex-smoker' clients were least likely to not attend for treatment (14.6% and 17.8%, respectively), $X^2(2) = 130.438$, p<.001.

Table 5.5 Attendance/Non-attendance (DNA) by Smoking Category

Smoking Category	**Attendance Type**				**Total**
	Attendance		**Non-Attendance (DNA)**		
	Number	**%**	**Number**	**% DNA**	
Never Smoked	3082	83.64	603	16.36	3685
Ex-Smoker	2377	82.22	514	17.78	2891
Current Smoker	14952	76.32	4639	23.68	19591
Total	**20411**		**5756**		**26167**
Total %	**74.71%**		**25.29%**		**100%**

$X^2(2) = 130.438$, p<.001



The above graph demonstrates that current smokers were more likely to DNA.

5.6 Overall Discharge Reason

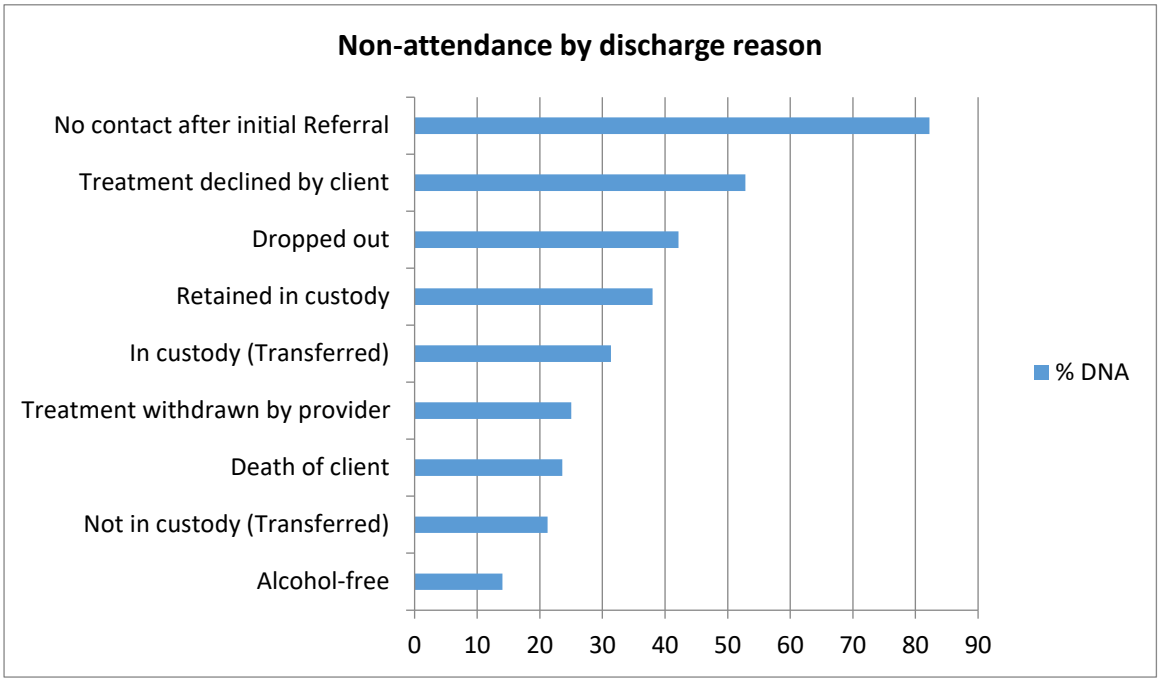
There was also a significant relationship found between non-attendance and overall discharge reason. The agency used two separate discharge categories, i) 'internal discharge' discharge from one aspect of the treatment such as tier 3 ii) the final discharge from the agency that is noted as 'overall discharge'. The results in Table 5.6 show that the clients who did not contact the agency (after initial referral) were most likely to not attend followed by treatment incomplete/commencement declined by the client (82.2% and 52.8 % respectively), whereas the 'treatment completed alcohol free' clients were least likely to not attend for treatment (14.0%), $X^2(9)$, 19308.241, p<.001.

Table 5.6 Attendance/Non-attendance (DNA) by Discharge Reason

Discharge Reason	**Sub-category**	**Attendance Type**				**Total**
		Attendance		**Non-Attendance (DNA)**		
		Number	**%**	**Number**	**% DNA**	
No contact	No contact after initial Referral	941	17.75	4361	82.25	5302
Incomplete	Death of client	1504	76.42	464	23.58	1968
	Dropped out	19692	57.85	14349	42.15	34041
	Retained in custody	660	61.97	405	38.03	1065
	Treatment declined by client	5058	47.18	5663	52.82	10721
	Treatment withdrawn by provider	708	75	236	25	944
Transferred	In custody	1398	68.66	638	31.34	2036
	Not in custody	10003	78.76	2698	21.24	12701
	Alcohol-free	30227	85.96	4937	14.04	35164

Treatment completed	Occasional user (not opiates or crack)	26435	82.03	5790	17.97	32225
Total		**96626**		**39541**		**136167**
Total %		**70.96%**		**29.04%**		

$X^2(9)$, 19308.241, p<.001.



The above graph demonstrates that client who 'made no contact after the initial referral' clients more likely to DNA.

5.7 Event type (Type of session)

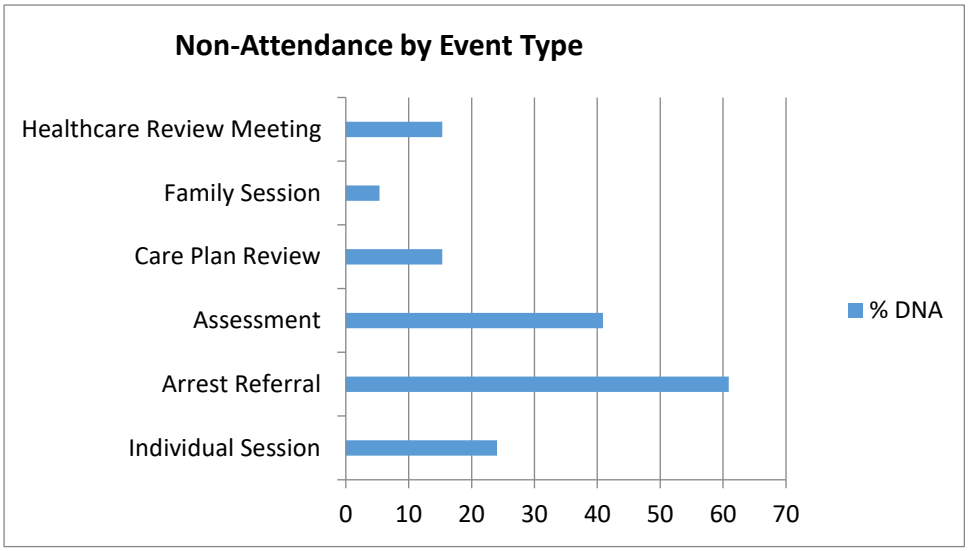
Chi square analysis revealed non-attendance varied significantly across the event types. Cross tabs in Table 5.7 shows non-attendance was highest in the Arrest Referral group (referred by Police) 60.9%, followed by Assessment (1st appointment, not included Arrest Referral clients) 40.9%. However, family focused sessions have lowest non-attendance rate compared to other event types, X^2 (5) = 7618.016, p<0.001.

Table 5.7 Attendance/Non-attendance (DNA) by Event Type

Event Type	**Attendance Type**				**Total**
	Attendance		**Non-Attendance (DNA)**		
	Number	**%**	**Number**	**% DNA**	
Individual Session	79400	75.96	25127	24.04	104527
Arrest Referral	910	39.12	1416	60.88	2326
Assessment	22023	59.1	15242	40.9	37265
Care Plan Review	7677	84.65	1392	15.35	9069

Family Session	4204	94.62	239	5.38	4443
Healthcare Review Meeting	5790	84.67	1048	15.33	6838
Total	**120004**		**44464**		**164468**
Total %	**72.96%**		**27.04%**		**100%**

X^2 (5) = 7618.016, p<0.001



The above graph demonstrates that 'arrest referral' clients more likely to DNA.

5.8 Non-attendance by team/site

Chi square analysis revealed non-attendance varied significantly across the teams/sites (locations). Cross tabs in Table 5.8 shows non-attendance was highest in Site 1 (32.7%) followed by Site 2 (29.6%). In contrast, Site 3 had the lowest non-attendance rate compared to other teams at 9.3%, $X^2(9) = 3213.266$, p<0.001.

Site 3 was the only site of the 10 sites that offered Social Behaviour and Network Therapy to all their clients, that is, it involved family members in the client's treatment as well as offering family interventions in their own right.

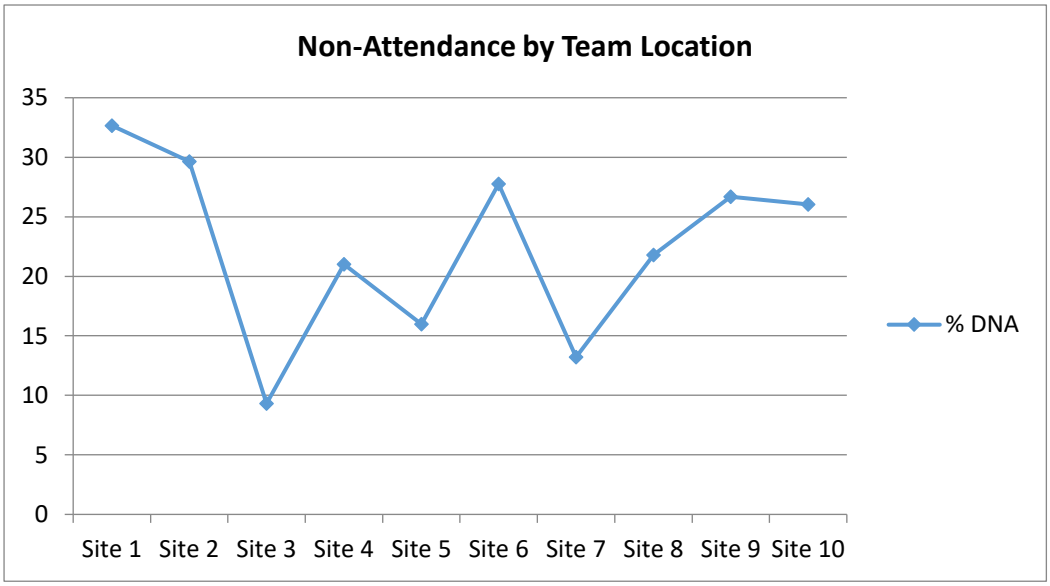
Due to confidentiality purposes the actual names of the sites are not provided.

Table 5.8 Attendance/Non-attendance (DNA) by Site

Team Location	**Attendance Type**				**Total**
	Attendance		**Non-Attendance (DNA)**		
	Number	**%**	**Number**	**% DNA**	
Site 1	50091	67.34	24298	32.66	74389
Site 2	57	70.37	24	29.63	81
Site 3	3021	90.69	310	9.31	3331

Site 4	15569	78.98	4143	21.02	19712
Site 5	7415	84.01	1411	15.99	8826
Site 6	4182	72.23	1608	27.77	5790
Site 7	3099	86.78	472	13.22	3571
Site 8	12885	78.21	3590	21.79	16475
Site 9	22409	73.31	8159	26.69	30568
Site 10	1276	73.97	449	26.03	1725
Total	**120004**		**44464**		**164468**
Total %	**72.96%**		**27.04%**		**100%**

$X^2(9) = 3213.266$, $p<0.001$



The above graph demonstrates that the site 1 clients were more likely to DNA.

5.9 Non-attendance by current employment status

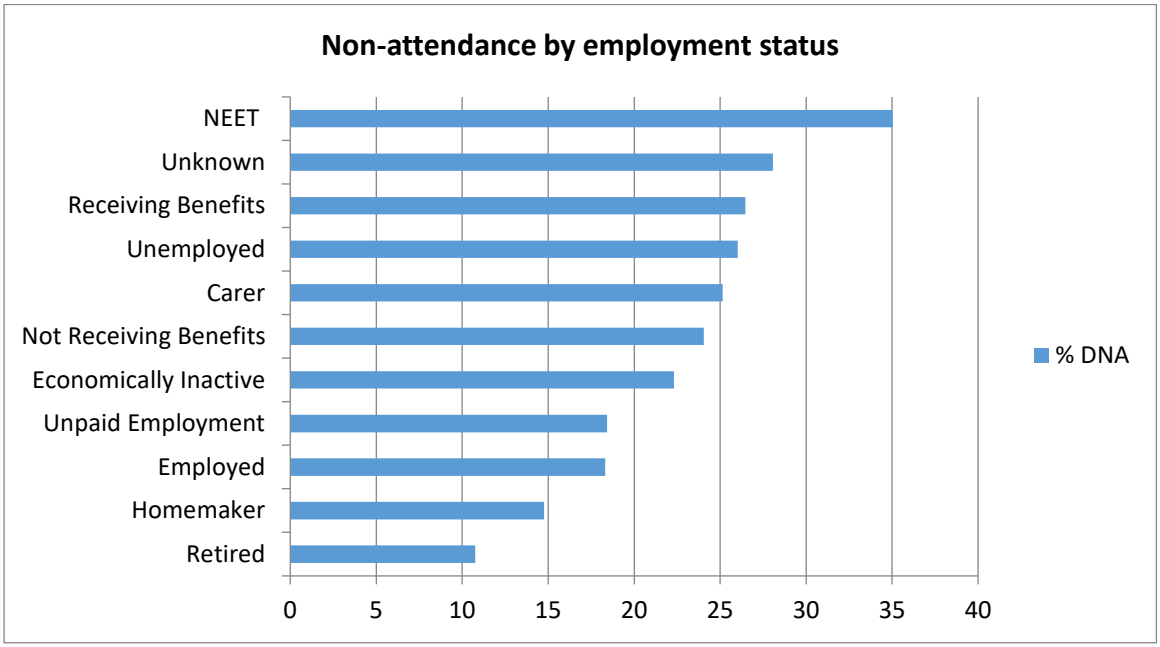
Chi-square analysis revealed a significant relationship between non-attendance and current employment status of the client. Cross tabs in Table 5.9 shows non-attendance was highest in two groups 'NEET (not in education, employment, or training) and 'unknown employment status' i.e. 35% and 28.1% and respectively. In contrast, 'Retired from paid work' group was least likely to not attend ($X^2(10) = 1511.503$, $p<0.001$).

Table 5.9 Attendance/Non-Attendance (DNA) by Employment Status

Employment Status	**Attendance Type**				**Total**
	Attendance		**Non-Attendance (DNA)**		
	Number	**%**	**Number**	**% DNA**	
Carer	128	74.85	43	25.15	171

Homemaker	3679	85.24	637	14.76	4316
Economically Inactive	22193	77.69	6372	22.31	28565
Receiving Benefits	5453	73.53	1963	26.47	7416
Not Receiving Benefits	1990	75.95	630	24.05	2620
NEET (Not in Education, Employment, or Training)	89	64.96	48	35.04	137
Unknown	5671	71.93	2213	28.07	7884
Unpaid Employment	2705	81.57	611	18.43	3316
Employed	22113	81.68	4960	18.32	27073
Unemployed	36284	73.98	12759	26.02	49043
Retired	5573	89.24	672	10.76	6245
Total	**105878**		**30908**		**136786**
Total %	**77.40%**		**22.60%**		**100%**

$X^2(10) = 1511.503, p<0.001$



The above graph demonstrates that NEET (not in education, employment, or training) clients more likely to DNA.

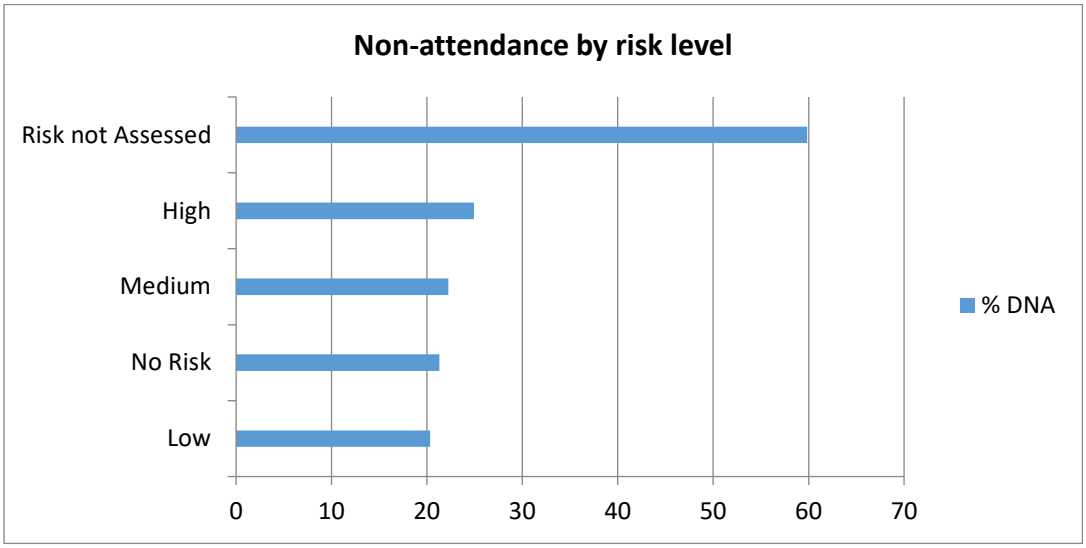
5.10 Risk levels

There was a significant relationship between non-attendance and risk levels. Table 5.10 shows that the group most likely to not attend was 'not risk assessed' (59.8%), followed by clients who were high risk (24.9%). In contrast, the 'no risk' group was most likely to attend (78.7% attendance), $X^2(4) = 13642.889, p<.001$).

Table 5.10 Attendance/Non-Attendance (DNA) by Risk Level

Risk Level	Attendance Type				Total
	Attendance		Non-Attendance (DNA)		
	Number	%	Number	% DNA	
High	21740	75.07	7219	24.93	28959
Medium	45300	77.77	12948	22.23	58248
Low	34861	79.67	8897	20.33	43758
No Risk	9489	78.71	2567	21.29	12056
Risk not Assessed	8614	40.16	12833	59.84	21447
Total	**120004**		**44464**		**164468**
Total %	**72.96%**		**27.04%**		**100%**

$X^2(4) = 13642.889, p<.001$



The above graph demonstrates that clients who were not risk assessed were more likely to DNA.

Appendix K Template Analysis – Templates

Practitioner Interviews

Template 1

I'll come in when I'm ready!

- Oh I forgot!
    - Forgetfulness
    - Conflicting commitments
- Practitioners' views
    - Fear of change
    - Vote with their feet!
- Client characteristics
    - Age
    - Ethnicity
    - Complex needs
    - Housing issues
    - Financial issues
    - Working people

Motivation

- Client recovery stage
- Motivation wavers
- Motivation – a dynamic force

There is always something to do

- Feeling relieved when clients DNA ('only sometimes!')
- Risks of target culture
- Funding cuts

What needs to happen

- Change of paradigm
    - Flexible and proactive engagement
    - Outcome focused and goal orientated
    - Focus on life instead of (only) alcohol!
    - Attending 'drop in' groups increases engagement

- How to further improve
    - More funding: more staff, more spaces, more resources
    - Creativity, versatility and accessibility
    - Clear treatment pathways
    - Use of volunteers and peer support

Template 2

'I'll come in when I'm ready'

- Why and which clients DNA
    - Clients' characteristics
    - Patterns linked with DNA

- Client reported reasons of DNA
- Service related factors
    - Waiting times
    - Location of the service

'Magic spark'

- Client recovery stages
- Motivation wavers
- Co-created motivation to work together

Treatment system relies on clients DNA

- Feeling relieved when clients DNA
- Function of DNA
- We need DNAs

'Change of paradigm'

- Flexible and proactive engagement
    - More funding: more staff, more spaces, more resources
- Outcome focused, clear pathways and goal orientated
- New ways of working
    - Use of volunteers and peer support
    - Outpatient appointment model is outdated

Reasons for non-attendance

- Why and which clients DNA
    - Clients' characteristics
    - Patterns linked with DNA

- Client reported reasons of DNA
- Service related factors
    - Waiting times
    - Location of the service

'Magic spark': Co-created motivation to attend

- Client recovery stages
- Motivation wavers
- Co-created motivation to work together

Function of DNA

- Feeling relieved when clients DNA
- Funding cuts
- 'There is always something else to do'

What needs to happen: 'Change of paradigm'

- Flexible and proactive engagement
    - More funding: more staff, more spaces, more resources
- Outcome focused, clear pathways and goal orientated
- 'Focus on life instead of (only) alcohol'
- Creativity, versatility and accessibility
    - Use of volunteers and peer support
    - Outpatient appointment model is outdated

Template 4

Reasons for non-attendance

- Why and which clients DNA
    - Clients' characteristics
    - Patterns linked with DNA

- Client reported reasons of DNA
- Service related factors
    - Waiting times
    - Location of the service
    - Funding cuts

'Magic spark': Co-created motivation to attend

- Motivation wavers
- Co-created motivation to work together

'DNA: system's need'

- Feeling relieved when clients DNA
- 'There is always something else to do'

What needs to happen: 'Change of paradigm'

- Flexible and proactive engagement
    - More funding: more staff, more spaces, more resources
- Outcome focused, clear pathways and goal orientated
- 'Focus on life instead of (only) alcohol'
- Creativity, versatility and accessibility
    - Use of volunteers and peer support
    - Outpatient appointment model is outdated

Template 5

Reasons for non-attendance

- Clients' characteristics
- Patterns linked with DNA
- Client reported reasons for DNA
- Service related factors
    - Waiting times
    - Location of the service
    - Funding cuts

'Magic spark': Co-created motivation to attend

- Motivation wavers
- Co-created motivation to work together

DNA: a system's need

- Feeling relieved when clients DNA
- 'There is always something else to do'

What needs to happen: 'Change of paradigm'

- Creative engagement
- Being flexible
- Proactive follow up

Focus Group

Template 1

- Reasons for non-attendance
    - Client related factors
    - Denial
    - Emotional health
    - Relapse
    - Other commitments
- Service related factors
    - Practitioners
    - Assessment process
    - Environment
    - Venue
    - Transport

- Client-practitioner relationship
- How can it be improved?